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79-1404

In the Supreme Court of the United States

October Term, 1979
No.

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,
Petitioners

v.

TERRI LEE HALDERMAN, et al.,
PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, et al.
and
UNITED STATES OF AMERICA,
Respondents

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Helen O'Bannon, Secretary of the Department of Public Welfare, Commonwealth of Pennsylvania, *et. al.*, hereby petition that a Writ of Certiorari issue to review the judgment of the United States Court of Appeals for the Third Circuit entered in this case on December 13, 1979.

I. OPINIONS OF THE COURTS BELOW

The majority and dissenting opinions of the Court of Appeals, reproduced at 89a to 196a, are not yet reported.

The opinion and order of the District Court is reported at 446 F. Supp. 1295 (E.D. Pa. 1978) and is reproduced at 6a to 75a.

II. JURISDICTION

The judgment of the Court of Appeals was entered on December 13, 1979. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §1254 (1).

III. STATEMENT OF QUESTIONS PRESENTED

1. Does The Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000 *et seq.*, grant residents of a State institution for the mentally retarded an enforceable right to treatment in the least restrictive setting when that institution receives no funds under that Act and when the State receives only minimal funding?

2. Does The Developmentally Disabled Assistance and Bill of Rights Act require a State to create and fund community-based mental retardation treatment facilities irrespective of cost, available resources, or State policy?

3. Does the United States have standing or authority to intervene in this case?

4. Does the District Court's exercise of detailed control over the decree of deinstitutionalization and its subsequent delegation of authority to a special master exceed the proper scope of federal judicial authority?

5. Did the Court of Appeals properly conclude that State law grants the mentally retarded a right to treatment, particularly when that holding is insufficient to impose liability?

IV. STATUTORY AND REGULATORY PROVISIONS INVOLVED

The following statutory and regulatory provisions relevant to this petition are set forth verbatim in the Appendix hereto:

Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000, *et seq.* (1977):

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Rule 53, Fed. R. Civ. P., 220a.

Penna. Mental Health and Mental Retardation Act of 1966, Pa. Stat. Ann. Tit. 50 §4101, *et seq.* (Purdon):

Sections 201 (1), 509 (1 and 5) 225a

V. STATEMENT OF THE CASE

On February 15, 1966, Terri Lee Halderman was voluntarily admitted by her parents to Pennhurst Center, one of approximately ten state-run institutions providing care for the mentally retarded in Pennsylvania. Dissatisfied with the services and facilities at Pennhurst, her mother commenced this action in May 1974 against a host of state officials from the Secretary of Welfare to Pennhurst staff.

On behalf of all other Pennhurst residents,[1] she sought damages and broad equitable relief aimed at upgrading the conditions at Pennhurst, claiming that those conditions violated her constitutional "right to treatment". She also alleged violations of the Equal Protection Clause of the Fourteenth Amendment, and the Pennsylvania Mental Health and Mental Retardation Act of 1966. Pa. Stat. Ann. tit. 50 §4101 *et seq.* (Purdon).

Subsequently, the plaintiff was joined in her efforts by the United States,[2] Pennsylvania Association of

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[1] A class was certified pursuant to Rule 23(b) (1 and 2), Fed. R. Civ. P., to include:

> All persons who as of May 30, 1974 and at any time subsequent, have been or may become residents of Pennhurst State School and Hospital (14a).

[2] Defendants unsuccessfully opposed the United States' intervention. They also unsuccessfully sought mandamus or prohibition against the district court judge to prohibit the continued participation of the United States in the litigation. *Beal v. Broderick*, 431 U.S. 933 (1977).

Retarded Citizens, and other retarded residents of Pennhurst. Intervenors raised similar, if not identical, claims.

In early 1976, plaintiffs amended their complaints and their prayer for relief. Adding claims under the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. §6000 *et seq.* (hereinafter "Developmental Disabilities Act"), and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794,[3] plaintiffs contended that Pennsylvania was required to close its institutions such as Pennhurst and provide services to the retarded in small-scale, community-based facilities[4] instead.

Following thirty-two days of trial, the District Court issued its opinion and order.[5] The court did not address plaintiffs' claims under the Developmental Disabilities Act, but did grant the injunctive relief requested. The court found that plaintiffs had a constitutional right to be provided with education, training and care sufficient to reach their maximum development (57a) in the least restrictive environment (62a). "[I]nstitution[s] such as Pennhurst", the court concluded, were by their very nature incapable of providing adequate care (58a). Additionally, the court held that treatment at Pennhurst was unlawful segregation under the Fourteenth Amendment (68a) and Section 504 of the Rehabilitation Act (73a). Section 504, the court concluded, "codified the constitutional right to equal protection" (71a).

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[3] The United States, although charged with the enforcement of these statutes, did not join other plaintiffs in these claims.

[4] These facilities are referred to by the Court as Community Living Arrangements ("CLAs"). Neither plaintiff nor the Court have ever defined the precise nature of these facilities (191a, n.5).

[5] The opinion was issued December 23, 1977 and the order March 17, 1978.

Implementing that decision, the court ordered sweeping injunctive relief, including the closing of Pennhurst and its replacement by "suitable community living arrangements" and all necessary support services (79a-80a) for all of the approximately 1,200 residents of Pennhurst (19a). A Special Master with broad powers over the detail of implementation was also appointed (79a).

On appeal, the Court of Appeals[6] implicitly rejected the District Court's holding that Pennhurst was *per se* illegal and/or unconstitutional. However, with three judges dissenting, the court did find that the Developmental Disabilities Act granted a right to treatment in "the least restrictive environment" (130a-131a). In reaching that issue, the court determined that the statute created a private cause of action. It also found a state statutory right to treatment and affirmed the order of the District Court permitting the United States to intervene as a plaintiff.

Based exclusively on its interpretation of the Developmental Disabilities Act, the Court of Appeals affirmed the District Court in most material respects.[7] Thus, on remand, the District Court or its appointed Master must determine the therapeutic needs of each patient at

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[6] The case was first heard by a panel of the court in January of 1979. That panel issued no opinion; instead, the Court scheduled reargument before the Court en Banc, held September 6, 1979. It also requested briefing on specified issues, including the Developmentally Disabled Act, which had not previously been briefed to that court or the District Court.

[7] The Court of Appeals affirmed the District Court except insofar as it directed the closing of Pennhurst, barred all future admissions to Pennhurst and required defendants to find alternative employment for all Pennhurst employees (161a).

Pennhurst. "Only where the court or the Master finds that an improved Pennhurst is the only appropriate place for individual patients should it be used. For all other patients, CLAs must be provided." (160a)

It is from this decision that the defendants, hereinafter referred to as petitioners, seek a writ of certiorari.

VI. REASONS FOR GRANTING THE WRIT

A. This Case Presents Questions of Great Public Importance

The court below decided at least two novel and important federal statutory issues. Breaking entirely new ground, the court held that the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000, *et seq.* (hereinafter "Developmentally Disabled Act"), (1) applies to programs such as Pennhurst which receive no funds under its provisions and (2) grants mentally retarded persons a right to treatment "in the least restrictive environment", which requires a state to create new, less restrictive facilities for persons residing in state institutions.

Accordingly, each state which, like Pennsylvania, accepts the minimal funding available under the Developmentally Disabled Act must, regardless of cost, available resources, or state policy, create whatever new facilities are necessary to provide services to the mentally retarded in the least restrictive environment. Moreover, that holding judicially mandates one method of caring for the mentally retarded to the exclusion of others, seriously intruding into areas properly reserved for professional expertise and state legislative and executive judgment. *Secretary of Public Welfare v. Institutionalized Juveniles,* 99 S.Ct. 2523 (1979); *Bell v. Wolfish,* 99 S.Ct. 1861 (1979).

In 1976, there were over 150,000 mentally retarded persons in the United States residing in institutions similar to Pennhurst (13a-14a, n.7). The reasoning of the court below applies with equal force to each of those persons, each of those institutions, and each state of the Union.[8] In short, the Court of Appeals effected a total federal preemption in the area of services for the developmentally disabled. Indeed, the decision raises grave doubts as to many other programs in which states receive federal funding but in which state discretion has been long recognized. *See,* e.g., Title XIX of the Social Security Act, 42 U.S.C. §1396, *et seq.*

In addition, instead of stating the appropriate legal standards and enjoining the Petitioners to implement relief, the District Court has maintained direct supervisory power over the detail of implementation through appointment of a master. This raises grave questions concerning the power and capabilities of federal courts to intervene into the daily activities of state and local governments. *See Rizzo v. Goode,* 423 U.S. 362 (1976).

Finally, the participation of the United States in this action, affirmed by the court below, presents significant questions regarding "case or controversy" requirements. The expansion of executive authority approved in this case has broad impact. *Estelle v. Justice,* 426 U.S. 925, 929 (1976) (Rehnquist J. dissenting).

Because this case involves issues of great public importance, this Court should grant review in this case.

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[8] All fifty states presently accept funds under the Act. President's Budget, 1979, Developmentally Disabled Basic State Formula Grant. Thus, this case has a direct bearing on every public institution in the United States serving the mentally retarded.

B. The Decision of the Court of Appeals Is Erroneous

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1. The court below has erroneously held that the Developmentally Disabled Act provides Respondents with a right to treatment in the least restrictive environment.

a. The court below held that the Developmentally Disabled Act provides rights to mentally retarded persons residing at Pennhurst, notwithstanding the absence of any finding that the institution receives any funds whatsoever under the statute. Thus, the court below found that by accepting any funds under that Act, Pennsylvania consented to comply with the statutory guidelines in each of its many programs providing services to the developmentally disabled (118a-119a).[9]

The Court of Appeals overlooked, however, the obvious fact that the Developmentally Disabled Act is exclusively a funding statute, providing federal grants to states electing to participate in the program. 42 U.S.C. §6063; *United States v. Solomon,* 419 F. Supp. 358, 369-70 (D. Md. 1976), *aff'd* 563 F.2d 1121 (4th Cir. 1977). Accordingly, a state seeking funds under the Act must have a plan approved by the Secretary of Health, Education and

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[9] In dicta, the court below suggested that the Act was an exercise of congressional power under the Fourteenth Amendment (117a-118a, n. 20). In the absence of a decision by this Court recognizing a constitutional right to treatment in the least restrictive environment, such a holding would raise serious questions concerning the congressional power to define the parameters of the Fourteenth Amendment. Cf. *Oregon v. Mitchell,* 400 U.S. 112 (1970); *Katzenbach v. Morgan,* 384 U.S. 641 (1966).

Welfare, 42 U.S.C. §6063(a), based upon compliance with the conditions outlined in 42 U.S.C. §6063(b).

By their terms, the conditions of participation apply only to programs receiving funds under the Act. *See,* e.g., 42 U.S.C. §6063(b)(5)(A)(22). Protection of the rights enunciated in 42 U.S.C. §6010 is limited to "all persons . . . receiving treatment, services, or habilitation under programs assisted under this chapter. . . ." 42 U.S.C. §6063(b)(6)(C). Even the basic requirement of a habilitation or treatment plan was intended to apply only to treatment programs funded by the Act. 42 U.S.C. 6011(a). *See also,* Conf. Rep. No. 94-473, 94th Cong., 1st Sess. 43, reprinted in 2 U.S. Code Cong. & Ad. News, 919, 963 (1975).

Moreover, the lower court's broad reading of the Act ignores the practicalities of providing services to the many thousands of developmentally disabled persons in Pennsylvania. For example, the cost in 1976 of operating Pennhurst alone was $27.8 million (44a), itself but a small part of Pennsylvania's expenditures on behalf of the mentally retarded. In contrast, Congress authorized appropriations under the Act totaling only $55 million for the fiscal year ending September 30, 1979, 42 U.S.C. §6061, of which Pennsylvania received approximately $1.6 million. Surely Congress did not intend that this minimal funding to Pennsylvania would require a total restructuring at substantial cost of programs receiving no funding under the Act.

In those instances when Congress has intended to impose federal standards on all activities conducted by a recipient of federal funding, it has done so clearly. *See* e.g., Section 504 of the Rehabilitation Act of 1973, 29

U.S.C. §794 (1976); The Education for All Handicapped Children Act of 1975, 20 U.S.C. §§1401, *et seq.* (1976). Certainly, such an intent may not be lightly inferred. *Cf. Southeastern Community College v. Davis,* 99 S.Ct. 830 (1979).[10]

b. The Court of Appeals discerned in the Act a legislative "preference" for treatment in "the least restrictive environment" (97a, 141a). The court then elevated that "preference" to a mandatory duty to provide less restrictive treatment, regardless of cost of available funds. On that basis it affirmed the District Court's order requiring the creation of community-based facilities.[11] In so doing, it exceeded even the broad statutory mandate which it had established.

Even if the Developmentally Disabled Act applies to those persons residing at Pennhurst and, in addition, provides those persons a right to treatment while there, it certainly imposes no duty on Pennsylvania to create new facilities. Nowhere does the Act mandate the provision of services to the developmentally disabled. Rather, at most, it sets forth standards which must be met by those services which are offered. Thus, even assuming that the

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[10] Under the reasoning in this case, because Pennhurst receives funds under the Medical Assistance Program, Title XIX of the Social Security Act, 42 U.S.C. §1396, *et seq.* every state program eligible for funding under that statute would be required to comply with its standards, whether or not such programs wished to receive such funding. *See Beal v. Doe,* 432 U.S. 438 (1977).

[11] Even as interpreted by the court below, state law provides no basis for that order since the court acknowledged that all state law requires "is that to the extent Pennsylvania maintains facilities for the mentally handicapped, *those* facilities must provide adequate treatment or habilitation." (127a) (emphasis added).

Act bars Pennsylvania from providing services in a "more" restrictive environment, it does not require Pennsylvania to create new, less restrictive facilities.

As correctly noted by Chief Judge Sietz in dissent, "Congress intended the Act to be no more than an incentive to deinstitutionalization, not an imposition of a mandatory requirement regardless of fiscal concerns." (168a) Regulations implementing the Act, e.g., 45 C.F.R. §§1385.1, 1386.42-.43, confirm its modest purposes. See also House Rep. No. 94-58, 94th Cong., 1st Sess. 10, reprinted in 2 U.S. Code Cong. & Ad. News, 919, 928 (1975).

Similarly, the court's heavy reliance on Section 6010, providing a "Bill of Rights", is clearly misplaced. As Chief Judge Sietz properly stated:

> I do not believe especially with a funding statute such as the one here, that general findings and declarations should be used as a charter for the creation of absolute obligations where Congress felt the states should be free to choose on their own as to the proper allocation of funds. . . . In sum, where Congress establishes a funding scheme designed to encourage a course of conduct, that is no license to federal courts to make that conduct mandatory. (168a-169a)

Cf. Southeastern Community College v. Davis, supra.

In short, the Developmentally Disabled Act imposes no affirmative duty to create services and facilities regardless of cost, but rather encourages the states to utilize their resources in a manner which recognizes the preferability of community placement. The decision of the Court of Appeals misconstrues this purpose in violation

of principles clearly established by this Court and in a manner which affects every state of the Union and thousands of their citizens. Accordingly, this Court should grant review of that decision.

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2. The court below erroneously and unnecessarily found that state law provides a right to treatment.

After finding a federal statutory right to treatment, the court below examined state law and found that it too provides a right to treatment. It did not, however, find in state law, as it had in the Developmentally Disabled Act, a requirement or "preference" that treatment be provided in the least restrictive environment. Thus, this state law holding was unnecessary and insufficient to support affirmance. *See Murdock v. City of Memphis,* 20 Wall. 590 (1875).

Even if the court properly considered state law, it misconstrued that law. The court below relied on Section 201 of the Pennsylvania Mental Health and Mental Retardation Act which provides in pertinent part:

> The department shall have power and its duty shall be: (1) to assume within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them. . .

Pa. Stat. Ann. Tit. 50 §4201 (Purdon). The court concluded that treatment was a mandated service.

However, the Court of Appeals stopped short of finding an "unconditional" state right to treatment (126a). Rather, the court held only "that to the extent

Pennsylvania maintains facilities for the mentally handicapped those facilities must provide adequate treatment or habilitation" (127a).

This limited holding is not supported by any decision of any court of state-wide jurisdiction. Moreover, in going even that far, the court completely ignored the legislative mandate that the Department of Public Welfare "assure . . . the *availability* and *equitable* provision of . . . adequate mental retardation services for all persons who need them." Pa. Stat. Ann. Tit. 50 §4201(1) (Purdon) (emphasis added). *See also,* Pa. Stat. Ann. Tit. 50 P.S. §4509 (Purdon).

In short, in deciding this difficult issue unnecessarily and without the assistance of meaningful state court precedent, the court wholly misinterpreted state law. For this reason, this Court should review the actions of the court below.

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3. The order of the court below exceeds the proper scope of federal judicial authority.

The Court of Appeals has vested in the District Court and its appointed master plenary discretion over the massive and sensitive task of developing community services for the retarded. Individual placement and treatment decisions are subject to the District Court's control (161a). The Master currently has complete authority to determine the community services to be provided, staffing needs, and monitoring systems, as well as to supervise the interim operation of Pennhurst (148a). In short, Petitioners have been stripped of their sovereign power.

The court's usurpation of state authority conflicts squarely with principles of comity repeatedly announced by this Court. *See,* e.g., *Rizzo v. Goode,* 423 U.S. 362, 377-380 (1976); *Doran v. Salem Inn,* 422 U.S. 922, 998 (1975). The "special delicacy" between "federal equitable power and state administration of its own law", *O'Shea v. Littleton,* 414 U.S. 488, 500 (1974), has been roughly cast aside. As it did in *Rizzo v. Goode,* the Court of Appeals has sanctioned an overly broad judicial intrusion into the internal affairs of state government.

Judicial intervention into the therapeutic process, as here, is especially troubling. The deference that must be accorded mental health professionals, *Parham v. J.R.,* 99 Sup. Ct. 2493 (1979); *Addington v. Texas,* 99 Sup. Ct. 1804 (1979), has not been recognized by the Court of Appeals. This error is accentuated by the District Court's finding that Petitioners are dedicated and qualified professionals (75a).

Finally, the court below ignored the limitations imposed by Rule 53, Fed. R. Civ. P. That rule authorizes reference to a master only in three narrow areas—matters of account, difficult computation of damages, and "upon a showing that some exceptional condition requires it". The latter phrase is narrowly construed. *LaBuy v. Howes Leather Co.,* 352 U.S. 249 (1957).

The exercise of "federal equitable power" and its subsequent delegation to a Master present an important issue concerning the power of federal courts to intrude into the actual operation of state government. Accordingly this Court should grant review of this case.

C. The Opinion of the Court Below Is in Direct Conflict With Decisions of the Fourth and Ninth Circuits Regarding the Authority of the United States To Seek Judicial Enforcement of the Rights of Mentally Retarded Persons

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The issue presented by the United States' participation in this lawsuit has previously been addressed by the Fourth Circuit in *United States v. Solomon,* 563 F.2d 1121 (4th Cir. 1977), and the Ninth Circuit in *United States v. Mattson,* 600 F.2d 1295 (9th Cir. 1979). The holding of the court below conflicts with both those decisions. *See also, In Re Estelle,* 516 F.2d 480, 487 (5th Cir. 1975), *cert. den. sub. nom, Estelle v. Justice,* 426 U.S. 925 (1976).

In *Solomon,* the United States brought an action charging the State of Maryland with violating the rights of mentally retarded residents of Rosewood State Hospital. The district court dismissed the action, holding that the United States lacked authority and, therefore, standing to bring it. The Fourth Circuit affirmed.

In so doing, the Fourth Circuit exhaustively examined both the relevant statutes and cases. The court found no express or implicit statutory authority for the government to sue, *Id.* at 1126, and rejected the argument that the lawsuit fell within the ambit of the rule that in certain limited areas the United States may sue without any express or implied statutory authority. *Id.* at 1129. The Ninth Circuit reached an identical result in *United States v. Mattson, supra,* expressly rejecting the government's argument that the Developmentally Disabled Act provides such approval.

The court below expressly considered and rejected the reasoning of the Fourth Circuit in *Solomon* (99a-102a). The lower court also attempted to distinguish *Solomon,* by relying on the fact that the United States had intervened in this action, rather than initiating suit as in *Solomon.*[12]

This ruling, however, overlooks the mandate of Article III, §2. Whether termed authority, standing or interest, the concept is the same: the United States has no legally cognizable stake in the operation of Pennhurst and thus no right to participate in this action. *Estelle v. Justice,* 426 U.S. 925, 929 (1976) (Rehnquist, J. dissenting); *Roe v. Wade,* 410 U.S. 113, 126-27 (1973); *Commonwealth Edison Co. v. Allis-Chalmers Mfg. Co.,* 315 F.2d 564, 567 (7th Cir. 1963). There is a clear division between the Circuits. Accordingly, review of this case is respectfully requested.

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[12] The court concluded that intervention was proper because plaintiffs had raised federal statutory claims. Ironically, the United States' complaint asserted no violation of any federal statute.

CONCLUSION

For the foregoing reasons, Petitioners respectfully request that a writ of certiorari issue to review the judgment of the Court of Appeals for the Third Circuit in this case.

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79-1436

JOINT APPENDIX

Supreme Court of the United States

October Term, 1979
No. 79-1515

PENNHURST STATE SCHOOL AND HOSPITAL et al.,
Petitioners

v.

TERRI LEE HALDERMAN, et al.
PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, et al.

and

UNITED STATES OF AMERICA,
Respondents

On Petitions for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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APPENDIX

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-1345

Terri Lee Halderman, et al.,
Plaintiffs

v.

Pennhurst State School and Hospital, et al.,
Defendants

United States of America,
Plaintiff-Intervenor

Pennsylvania Association for Retarded Citizens, et al.,
Plaintiff-Intervenors

ORDER

AND NOW, this 29th day of November, 1976, the Court having before it a number of motions which have been filed in connection with the above captioned matter, and having considered the pleadings and briefs of the parties, makes the following Orders in connection with said motions.

It is hereby ORDERED that:

1. The Motion to Dismiss filed by Commonwealth Defendants on July 12, 1974 is hereby denied.

2. The Motion to Dismiss Plaintiff-Intervenor, the United States of America, filed by Commonwealth Defendants on September 30, 1975 is hereby denied.

3. The Motion for Leave to File A Second Amended Complaint, filed by Plaintiffs, Terri Lee Halderman, et al., on March 31, 1976, is hereby granted.

4. The Motion to Dismiss filed by Defendants, Robert Strebl, Earl Baker, Leo McDermott and William A. McKendry on March 15, 1976, is hereby denied.

5. The Motion to Dismiss Plaintiff-Intervenor's, Pennsylvania Association for Retarded Citizens (P.A.-R.C.), Complaint in Intervention as Amended by Stipulation of Counsel filed by Commonwealth Defendants on April 5, 1976 is hereby denied.

5a. The Motion to Dismiss, or In the Alternative, to Strike the Amended Complaint in Intervention of P.A.-R.C. filed by the Commonwealth Defendants on April 5, 1976 is hereby denied.

6. The Court, having considered the Motion to Join Defendant Parties, filed on May 21, 1976 by Plaintiff-Intervenors, P.A.R.C., determines that said Motion is moot in that said Defendants will be before the Court after service of Plaintiffs' Terri Lee Halderman, et al., Second Amended Complaint.

7. The Motion to Dismiss filed by Defendants Frank Rizzo, the City Council of Philadelphia and Leon Soffer on June 1, 1976 is hereby denied.

8. The Motion to hold Commonwealth Defendants in Contempt of Court filed by Plaintiffs, Terri Lee Halderman, et al., on June 9, 1976 is hereby denied.

9. The Motion for a Protective Order to Seal All Discovery filed by Commonwealth Defendants on June 23, 1976 is hereby denied.

10. The Motion to Stay Discovery filed by Commonwealth Defendants on June 25, 1976 is hereby denied.

11. The Motion to Stay Discovery filed by Commonwealth Defendants on August 9, 1976, is hereby denied.

12. The Motion for a Protective Order filed by Commonwealth Defendants on August 23, 1976, is hereby denied.

13. The Motion to Compel Plaintiff-Intervenor, P.A.R.C., to Answer Interrogatories Number 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 20 and 22 of Commonwealth Defendants' First Set of Interrogatories filed on August 26, 1976, is hereby granted to the extent necessary to verify paragraph 4 of P.A.R.C.'s Amended Complaint insofar as the allegations of said paragraph pertain to the class of persons described in paragraph 15 of this Order.

14. The Motion to Compel Plaintiff-Intervenors, United States of America, to Answer Interrogatories Number 2, 3, 5, 6 and 7 of Commonwealth Defendants' First Set of Interrogatories to Plaintiff-Intervenor, United State of America, filed on November 28, 1975, is hereby denied.

15. In accordance with Rule 23(c) of the Fed. R. Civ. P., the Court determines that this litigation shall be maintained as a class action pursuant to Fed. R. Civ. P.

23(b)(1) and (b)(2); the Court having found that: (a) the class is so numerous as to make joinder of all members impracticable, (b) there are questions of law and fact common to the class and the claims of the plaintiffs are typical of the class and predominate over any questions affecting only individual members, (c) the named plaintiffs will adequately and fairly protect the interest of the class, (d) a class action is superior to any other available method for the fair and efficient adjudication of the controversy, (e) the prosecution of separate actions by or against individual members of the class would create a risk of inconsistent adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class, and (f) defendants have acted or refused to act on grounds generally applicable to the class thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole. The class shall consist of all persons who as of May 30, 1974, and at any time subsequent, have been or may become residents of Pennhurst State School and Hospital. The members of the class are persons resident at Pennhurst State School and Hospital, persons residing in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties who are on a waiting list for placement at Pennhurst State School and Hospital, and persons residing in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties who, because of the unavailability of alternate services in the community, may be placed at the Pennhurst State School and Hospital.

16. This Court's Order, dated October 4, 1976, staying discovery pending determination of the above motions is hereby VACATED.

17. It is further ORDERED that counsel for all parties shall meet in chambers, 10613 United States Courthouse, 601 Market Street, Philadelphia, Pennsylvania, on Wednesday, December 8, 1976, at 9:00 a.m., for the purpose of determining dates for the completion of a Pre-Trial Order and the Trial of this case.

(s) Raymond J. Broderick
Raymond J. Broderick, *J.*

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-1345

Filed Dec. 23, 1977

Terri Lee Halderman, a retarded citizen, by her mother and guardian, Winifred Halderman;

Larry Taylor, a retarded citizen, by his parents and guardians, Elmer and Doris Taylor;

Kenney Taylor, a minor, a retarded citizen, by his parents and guardians, Elmer and Doris Taylor;

Robert Sobetsky, a minor, a retarded citizen, by her parents and guardians, Frank and Angela Sobetsky;

Theresa Sobetsky, a retarded citizen, by her parents and guardians, Frank and Angela Sobetsky;

Nancy Beth Bowman, a retarded citizen, by her parents and guardians, Mr. and Ms. Horace Bowman;

Linda Taub, a retarded citizen, by her parents and guardians, Mr. and Mrs. Allen Taub;

George Sorotos, a minor, a retarded citizen, by his foster parents, William and Marion Caranfa, all of the above individually and on behalf of all others similarly situated;

The Parents and Family Association of Pennhurst,

Plaintiffs

Pennsylvania Association for Retarded Citizens,

Jo Suzanne Moskowitz, a minor, by her parents and next friends, Leonard and Nancy Moskowitz,

Robert Hight, a minor, by his parents and next friends, John and Jeanne Hight,

David Preusch, a minor, by his parents and next friends, Calvin and Elizabeth Preusch, and
Charles DiNolfi,

On behalf of themselves and all others similarly situated,
Plaintiffs-Intervenors

United States of America,
Plaintiff-Intervenor

v.

Pennhurst State School & Hospital,
Department of Public Welfare of the Commonwealth of Pennsylvania,

Frank S. Beal, Secretary of the Department of Public Welfare,

Stanley Meyers, Deputy Secretary for Mental Retardation, Department of Public Welfare,

Helene Wohlgemuth, Former Secretary, Department of Public Welfare,

Aldo Colautti, Executive Deputy Secretary, Department of Public Welfare,

Wilbur Hobbs, Deputy Secretary for Southeastern Region, Department of Public Welfare,

Russell Rice, Jr., Commissioner of Mental Retardation for Southeastern Region, Department of Public Welfare,

C. Duane Youngberg, Superintendent, Pennhurst State School & Hospital,

Robert Smilovitz, Former Assistant Superintendent, Pennhurst State School & Hospital,

Joseph Foster, Assistant Superintendent, Pennhurst State School & Hospital,

Margaret Green, Betty Uphold, Alice Barton, P. E. Klick,

Dr. Parocca, Helen Francis, employees and agent of Pennhurst State School & Hospital,

John Doctor, James Nurse, Jane Aide, Jill Therapist, Richard Roe, Jane Doe, unknown and unnamed staff, employees and agents of Pennhurst State School & Hospital, each individual Defendant sued individually and in his or her official capacity,

George Metzger, Joseph Catania, and Roger Bowers, Commissioners for Bucks County,

Robert Strebl, Earl Baker and Leo McDermott, Commissioners for Chester County,

Faith R. Whittlesey, Charles Keeler, and William Spingler, Commissioners for Delaware County,

A. Russell Parkhouse, Frank W. Jenkins and Lawrence H. Curry, Commissioners for Montgomery County,

Mayor Frank L. Rizzo and The City Council of Philadelphia, as Authorities for Philadelphia County,

Peter Bodenheimber, Mental Health/Mental Retardation Administration for Bucks County,

William A. McKendry, Mental Health/Mental Retardation Administrator for Chester County,

P. Paul Burrichter, Mental Health/Mental Retardation Administrator for Delaware County,

Hermann A. Roether, Mental Health/Mental Retardation Administrator for Montgomery County, and

Leon Soffer, Mental Health/Mental Retardation Administrator for Philadelphia County,

Defendants

OPINION

Broderick, *J.*, December 23, 1977.

This is a class action in which the named plaintiffs are either residents or former residents of Pennhurst State School and Hospital, now known as Pennhurst Center ("Pennhurst"), an institution owned and operated by the Commonwealth of Pennsylvania, located in Spring City, Pennsylvania. These plaintiffs are all retarded persons, or their representatives, who claim injury based on violations of certain state[1] and federal[2] statutes as well as violations of certain constitutional rights[3] in connection with their institutionalization at Pennhurst. The plaintiffs seek both damages and broad equitable relief including the closing of Pennhurst, and mandating that the defend-

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[1] 50 P.S. §§4101 *et seq.*, 4507, 4509.

[2] 29 U.S.C. §794; 42 U.S.C. §§1983, 1986, 6010.

[3] First, Eighth, Ninth, and Fourteenth Amendments to the United States Constitution.

ants provide them with education, training and care in their respective communities. "Habilitation" is the term of art used to refer to that education, training and care required by retarded individuals to reach their maximum development.

This matter was tried before the Court, sitting without a jury, over a period of thirty-two days, testimony being limited solely to the issue of liability. In connection therewith, the Court makes the following findings of fact and conclusions of law:

Mental retardation, by definition, is an impairment in learning capacity and adaptive behavior.[4] (Roos, N.T. 1-86). Retardation is wholly distinct from mental illness. Retarded individuals, just as other members of society, may suffer from mental illness. Mental retardation is primarily an educational problem and not a disease which can be cured through drugs or treatment. However, with proper habilitation, the level of functioning of every retarded person may be improved. (Glenn, N.T. 5-186).[5]

The incidence of mental retardation is about 3% in the general population. There are four basic levels of mental retardation: (1) mild (I.Q. 52-69) which comprises 89% of the mentally retarded population; (2) moderate (I.Q. 36-51) which comprises 6% of the men-

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[4] Intelligence is generally measured through intelligence quotient tests (I.Q.), while ability to deal with social environment is measured through social quotient tests.

[5] An individual may be functioning at a retarded level due to lack of education and/or training, and once supplied with that education and/or training, may be removed from the ranks of the retarded.

tally retarded population; (3) severe (I.Q. 20-35) which in conjunction with (4) profound (I.Q. less than 20) comprises 5% of the mentally retarded population. (Roos, N.T. 1-89, 1-90).

Pennhurst, as an institution for the retarded, was on trial. Recent years have witnessed an assault upon such institutions.[6] At issue is whether the residents at Pennhurst have been the victims of violations of their statutory or constitutional rights; specifically whether Pennhurst as an institution has been violating the statutory or constitutional rights of its retarded residents in failing to provide them with minimally adequate education, training and care.

History is replete with misunderstanding and mistreatment of the retarded. As Wolfensburger points out in *The Origin and Nature of Our Institutional Models* 3 (1975):

> It is chastening to recall that the retarded in American history were long grouped with other types of deviant groups. In early America, the Puritans looked with suspicion on any deviation from behavioral norms, and irregular conduct was often explained in terms of the supernatural, such as witchcraft. There is reason to believe that retarded individuals were hanged and burned on this suspicion. Later in New England, records show that lunatics, "distracted" persons, people who were *non compos*

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[6] *See, e.g.*, Mason & Menolascino, *The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal and Scientific Interface*, 10 Creighton L. Rev. 124 (1976) [hereinafter cited as Mason & Menolascino].

mentis, and those who had "fits" were all classed together, perhaps with vagabonds and paupers thrown in. . . . Connecticut's first house of correction in 1722 was for rogues, vagabonds, the idle, beggars, fortune tellers, diviners, musicians, runaways, drunkards, prostitutes, pilferers, brawlers—and the mentally afflicted. . . . As late as about 1820, the retarded together with other dependent deviant groups such as aged paupers, the sick poor, or the mentally distracted were publicly "sold" ("bid off") to the *lowest* bidder, i.e., bound over to the person who offered to take responsibility for them for the lowest amount of public support. . . .

The 10th (1880) U.S. census first combined "defectives," "dependents," and "delinquents" for reporting purposes. The Public Health Service combined "criminals, defectives, and delinquents" as late as the 1920's.

The National Conference on Charities and Correction, between about 1875 and 1920, often grouped the idiotic, imbecilic and feeble-minded with the deaf, dumb, blind, epileptic, insane, delinquent and offenders into one general class of "defectives." Few of us today are aware of the fact that the more contemporary term "mental defective" was coined to distinguish the retarded from these other "defectives," and it is no coincidence that many state institutions were for both the retarded and the epileptic. During the "indictment period," discussed later, an incredible range of deviances were associated with retardation; indeed, they were seen to be caused by it: illness, physical impediments; poverty; vagrancy;

unemployment; alcoholism; sex offenses of various types, including prostitution and illegitimacy; crime; mental illness; and epilepsy. All these were called the "degeneracies."

Institutions for a number of "deviant" groups were founded in the United States in the mid-nineteenth century for the purpose of making the deviant less deviant. They were originally relatively small centers, often located within the community, in which intensive training could be concentrated on the deviants. Their emphasis was on education; they were viewed as temporary boarding schools, geared toward returning the individuals to their family or living group once appropriate skills were learned. By the late nineteenth century, however, these schools were replaced by asylums isolated from the community, where instead of providing the individual with the education and training necessary to return to the community, they provided the protection and care it was thought that these individuals required. The asylum grew to be viewed as a permanent residential facility for the deviant. In the more progressive states, the retarded received their own facilities separated from other "deviant" groups. With this concept came increased isolation and increased size permitting little time for habilitation. *See generally, W. Wolfensberger,* supra at 24-56. Pennhurst was the product of this era.[7]

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[7] From 1860 to 1960 there had been a marked increase in the number of mentally retarded individuals residing in our nation's institutions. Since 1966, this number has been decreasing. In 1966, 99 out of every 100,000 mentally retarded individuals were institutionalized. By 1976, that number had dropped to 71 out of every 100,000. In 1976, 154,000 mentally retarded individuals

I. *Procedural History*

This action was commenced in May, 1974. On November 26, 1976, it was certified by the Court as a class action, with the plaintiff class of retarded persons defined as:

> All persons who as of May 30, 1974, and at any time subsequent, have been or may become residents of Pennhurst State School and Hospital. The members of the class are persons resident at Pennhurst State School and Hospital, persons residing in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties who are on a waiting list for placement at Pennhurst State School and Hospital, and persons residing in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties, who, because of the unavailability of alternate services in the community, may be placed at the Pennhurst State School and Hospital.

On February 4, 1977, by agreement of the parties, we entered an Order trifurcating the trial. This Order reads, in pertinent, part, as follows:

> Said trial will be bifurcated—the first phase limited solely to the issue of liability. At such time as the Court issues its findings of fact and conclusions of law thereafter, a date shall be set for the second phase of the trial—to determine what relief, if any, a federal court can and should grant in this situation. At the conclusion of the second phase of the

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were residing in state public institutions, 32,000 were in hospitals for the mentally ill and 32,000 were in private institutions of various kinds. (Roos, N.T. 1-92, 1-93).

trial, a date shall be set for the third phase of the trial, if one is deemed necessary,—to determine damages due Plaintiffs.

The first phase of this non-jury trial began on April 18, 1977 and ended on June 13, 1977, occupying thirty-two court days.

II. *The Parties*

The original complaint in this action was filed as a class action by Terri Lee Halderman, a retarded individual who had been admitted to Pennhurst on the application of her parents pursuant to 50 P.S. §4402[8] in 1966. On

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[8] 50 P.S. §4402 provides:

(a) Application for voluntary admission to a facility for examination, treatment and care may be made by:

(1) Any person over eighteen years of age.

(2) A parent, guardian or individual standing in loco parentis to the person to be admitted, if such person is eighteen years of age or younger.

(b) When an application is made, the director of the facility shall cause an examination to be made. If it is determined that the person named in the application is in need of care or observation, he may be admitted.

(c) Except where application for admission has been made under the provisions of section 402(a)(2) and the person admitted is still eighteen years of age or younger, any person voluntarily admitted shall be free to withdraw at any time. Where application has been made under the provisions of section 402(a)(2), only the applicant or his successor shall be free to withdraw the admitted person so long as the admitted person is eighteen years of age or younger.

(d) Each admission under the provisions of this section shall be reviewed at least annually by a committee, appointed by the director from the professional staff or the facility wherein the person is admitted, to determine whether con-

July 29, 1974, the first amended complaint was filed, adding as name plaintiffs seven other retarded individuals[9] who had been admitted to Pennhurst upon the application of their parents. The amended complaint also added as a plaintiff the Parents and Family Association of Pennhurst representing 200 parents of retarded residents at Pennhurst. The Association was organized in 1967 to protect the rights of retarded citizens at Pennhurst and other institutions. (First amended complaint at 4).

On January 17, 1975, the Court granted the United States of America leave to intervene as a party plaintiff.[10] On November 12, 1975, the Court, without opposition, granted leave to intervene to the Pennsylvania Association for Retarded Citizens ("PARC") and four retarded individuals,[11] three of whom were court committed to

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tinued care is necessary. Said committee shall make written recommendations to the director which shall be filed at the facility and be open to inspection and review by the department and such other persons as the secretary by regulation may permit.

Where the admission is under the provisions of section 402(a)(2), the person admitted shall be informed at least each sixty days of the voluntary nature of his status at the facility.

[9] Larry Taylor, Kenny Taylor, Robert Sobetsky, Theresa Sobetsky, Nancy Beth Bowman, Linda Taub, and George Sorotos.

[10] On November 29, 1976, we denied defendants' motion to dismiss the United States for lack of standing. Defendants' attempt to mandamus this Court to dismiss the United States failed. *Beal v. Broderick,* F.2d , (3d Cir. 1976), *cert. denied,* U.S. (1977).

[11] Jo Suzanne Moskowitz, Robert Hight, David Perusch, and Charles DiNolfi.

Pennhurst pursuant to 50 P.S. §4406[12] or an earlier statute. PARC is a non-profit corporation which was founded in 1950 (Schmidt, N.T. 14-108) and has mem-

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[12] 50 P.S. §4406 provides:

(a) Whenever a person is believed to be mentally disabled, and in need of care or treatment by reason of such mental disability, and examination of such person has been made by a physician or physicians, or for any reason the examination of such person cannot be made, a petition may be presented to the court of common pleas of the county in which a person resides or is, for his immediate examination or commitment to an appropriate facility for examination, observation and diagnosis.

(1) The petition may be made by a relative, guardian, friend, individual standing in loco parentis, or by the executive officer or an authorized agent of a governmental or recognized nonprofit health and welfare organization or agency or any responsible person.

(2) The petition shall set forth the facts upon which the petitioner bases his belief of mental disability and the efforts made to secure examination of the person by a physician.

(3) Said court upon consideration of such petition shall: (i) issue a warrant requiring that such person be brought before said court; (ii) fix a date for a hearing which shall be as soon as the warrant is executed, and (iii) notify the parties in interest.

(4) After hearing, said court may: (i) order an immediate examination by two physicians appointed by said court, or (ii) order the commitment of the person believed to be mentally disabled, to a facility for a period not exceeding ten days for the purpose of examination. If the examination can be accomplished by partial hospitalization said court may so direct.

(b) If, upon examination, it is determined that such person is in need of care at a facility, the examining physi-

ber chapters in fifty-seven of Pennsylvania's sixty-seven counties; its purpose being to advance the interest of retarded persons in Pennsylvania. The members of PARC include parents, other relatives, guardians, and next friends of persons residing at Pennhurst, and those in jeopardy of residing there.

Defendants are: Pennhurst; the Pennsylvania Department of Public Welfare; various state and county[13] officials responsible for supervising the Commonwealth's and the counties' retardation programs; and the superintendent and various employees of Pennhurst.

III. *Education, Training and Care (Habilitation) Afforded the Retarded at Pennhurst*

Pennhurst, a residential institution for the retarded, was founded in 1908. It is owned and operated by the

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cians or director, as the case may be, shall immediately report to said court which may order the commitment of such person for care and treatment.

In its order of commitment, said court may permit partial hospitalization or outpatient care, or if at any time thereafter the director shall determine such partial hospitalization or outpatient care to be beneficial to the person so committed, the same may be permitted by said court upon application by the director.

The court in *Goldy v. Beal*, 429 F. Supp. 640 (M.D. Pa. 1976) (three-judge court) found this statute unconstitutionally vague with respect to the commitment of mentally ill persons. Pennsylvania's procedure for the involuntary commitment of mentally ill persons is now found in 50 P.S. §§7301-7306. The constitutionality of §4406 as it applies to the retarded is not challenged in this litigation.

[13] Representing Bucks, Chester, Delaware, Montgomery and Philadelphia Counties.

Commonwealth of Pennsylvania, and is located in Spring City, Pennsylvania about 30 miles from Philadelphia. Since its founding in 1908, the institution has been overcrowded and understaffed. (PARC Exhibit 40, R. Smilovitz, Pennhurst in Perspective: Purpose, Programs, Possibilities.) The present resident population is approximately 1,230, reduced from a high of nearly 4,000 in the early 1960's. (Youngberg N.T. 22-123). Its staff numbers approximately 1,500. All parties concede that the institution has undergone tremendous improvements since the 1950's when, at best, the residents' treatment could be described as "warehousing". Even with these improvements, it was admitted by the defendants that Pennhurst does not presently meet minimum standards for the habilitation of its residents. (Rice, N.T. 26-24; Youngberg, Deposition at 22-31).[14]

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[14] Pennhurst must satisfy both federal and state licensing standards to qualify for federal medical assistance (Title XIX funds), standards which Dr. Youngberg and Dr. Rice equated with minimally acceptable professional standards. (Rice, N.T. 27-57; Youngberg, Deposition at 27). Both the individual and the area in which he or she resides must be certified in order for the institution to qualify for funds. At Pennhurst only 16 out of the 40 living areas have been certified, though a majority of these areas have deficiencies. The deficiencies have either been waived, or Pennhurst has filed plans for correcting the deficiencies. (Pool, N.T. 18-27, 28-28). Five hundred fourteen residents live on these 16 wards and are eligible for funding. Another 600 Pennhurst residents would be eligible were they to reside on a certified ward. (*Id.*, N.T. 17-209).

To meet medical assistance living standards, the population of Pennhurst must be reduced to 850 residents. In addition, $1,028,327 is being expended to correct Life Safety Code, violations —the completion date of this project is December 31, 1977 (the

Approximately half of the residents at Pennhurst have been admitted upon application of their parents or guardians, while the other half have been committed by a court. (Youngberg, N.T. 22-122). No distinction is made in the services extended to either group. The average[15] resident age at Pennhurst is 36, and the average stay at the institution is 21 years. Forty-three percent of the residents have had no family contact within the last three years.[16] Seventy-four percent of the residents are severely to profoundly retarded.[17] The average resident has had one psychological evaluation every three years and one vocational adjustment service report every 10 years. Those residents who have had more than one Vineland examination (measuring social quotient) during their residency at the institution, have, on the basis of this test, shown a decline rather than an increase in social skills while at Pennhurst (they declined an average of 7.542 points during their residence at Pennhurst, a loss of .596 points per year.)[18]

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project was awarded in December, 1975, with an original completion date of April, 1977).

To meet medical assistance care standards, Pennsylvania is planning to expend an additional $2,367,500. (Rice, N.T. 26-6). The institution is presently in jeopardy of losing its current certification if the waivers it presently has, contingent on repairs being made, are withdrawn. (*Id.*, at 26-13, 26-14).

[15] The statistics set forth in this paragraph are taken from a systematic sampling of 10% of the resident population at Pennhurst. (PARC Exhibit 48).

[16] It is unclear what percentage of the residents have family members still living.

[17] See text following note 5, *supra*.

[18] It appears that the Vineland has an inherent bias against retarded individuals from age ten through twenty-five, in that social quotients over this period, as measured by the Vineland,

At its best, Pennhurst is typical of large residential state institutions for the retarded.[19] These institutions are the most isolated and restrictive settings in which to treat the retarded. (Lancaster-Gaye, N.T. 4-79). Pennhurst is almost totally impersonal. (*Id.*, N.T. 4-71). Its residents have no privacy (Roos, N.T. 1-149)—they sleep in large over-crowed wards (Youngberg, Deposition at 22), spend their waking hours together in large day rooms and eat in a large group setting. (Clements, N.T. 2-57, 2-71, 2-72). They must conform to the schedule of the institution which allows for no individual flexibility. Thus, for example, all residents on Unit 7[20] go to bed between 8:00 and 8:30 p.m., are awakened and taken to the toilet at 12:00—12:30 a.m. and return to sleep until 5:30 a.m. when they are awakened for the day (Barton, Deposition at 21-26, 33-34; Roos, N.T. 1-50), which begins with being toileted and then having to wait for a 7:00 a.m. breakfast.

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have a tendency to decline. (Hare, N.T. 8-195, 8-196). This phenomena ceases once the individual reaches the age of twenty-five. (*Id.*, N.T. 8-203). An analysis of those Pennhurst residents who had received at least two Vineland examinations since their twenty-fifth birthday showed an average regression of 2.3 points. (*Id.*, N.T. 9-16).

[19] Dr. Gunnar Dybwad, who has visited institutions for the retarded in 49 states testified that Pennhurst was in the bottom category of the large residential state institutions for the retarded. (N.T. 7-62).

[20] Pennhurst is organized around the unit system and is composed of nine units, representing various levels of educational and behavioral development and physical handicap. (United States of America Exhibit 10).

A. *Staffing*

On the whole, the staff at Pennhurst appears to be dedicated and trying hard to cope with the inadequacies of the institution. (Hersh, N.T. 13-130).[21] Many of the problems at Pennhurst result from overcrowding and understaffing.[22] As professionals leave the staff, they are often not replaced, their jobs being turned over to direct care staff; thus, in the last two years nineteen professionals have left the staff without being replaced. (Roos, N.T. 1-153). Nearly every witness who testified concerning Pennhurst stated that it was grossly understaffed to adequately habilitate the residents. None of the standard reference sources now generally used by professionals in the field of mental retardation define the qualifications and minimal numbers of mental retardation professionals necessary to provide minimally adequate programs of habilitation. (Clements Report at 6). However, the court in *Wyatt v. Stickney,* 344 F. Supp. 387 (N.D. Ala. 1972), attempted to provide such guidelines. A comparison of the *Wyatt* ratios to those at Pennhurst in 1975[23] reveals:

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[21] As defendants themselves have expressed it: "The staff at Pennhurst is a dedicated lot with precious little to work with." Commonwealth Defendants' Post-Trial Proposed Findings of Fact and Legal Arguments at 5.

[22] In his budget proposal for fiscal year 1977-78, Superintendent Youngberg requested 23 additional ward clerks, 1 additional unit secretary and 717 mental retardation aides. (Youngberg, Deposition at 42).

[23] There was no testimony that these ratios have changed dramatically in the intervening two years, though 19 professional positions have been eliminated since Dr. Clements' tour of Pennhurst. (Roos, N.T. 1-153).

	Wyatt Standards	*Pennhurst*
a. Psychologists	23	23
b. Social Workers	40	6
c. Vocational Therapists	5	4
d. Recreation Therapists	23	0
e. Occupational Therapists	18	10
f. Registered Nurses	95	54
g. Physicians	7	6
h. Physical Therapists	14	2
i. Speech and Hearing Therapists	14	9
j. Dentists	7	4
k. Chaplains	7	4
l. Teachers[24]	51	8

(Clements, N.T. 2-26, 2-27).

No psychologists are on duty at Pennhurst at night or over the weekend, thus, if a resident has an emotional crisis, he or she may go without treatment until the next morning or until the weekend is over. (Riznyk, N.T. 17-182). Moreover, routine housekeeping services are not available during evenings and weekends, thus it is common to find urine and feces on ward floors over these periods. (Smith, Deposition at 41; Roos, N.T. 1-158).

B. *Habilitation at Pennhurst*

All parties to this litigation are in agreement that Pennhurst as an institution is inappropriate and inadequate for the habilitation of the retarded. It is also admitted

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[24] In 1975, 206 school age residents were enrolled in the school program operated by IU teachers. These teachers were excluded from the calculation.

that the inadequacies in programming at Pennhurst are directly attributable to staff shortages. Residents' records commonly contain a notation that they would benefit from specific types of programming. However, such programming has, for the most part, been unavailable to the individual because of staff shortages. (Foster, Deposition at 42; DeAngelis, N.T. 16-49). The average resident receives only 1½ hours of programming per weekday and no programming on weekends. (Thurman, N.T. 14-60; DeAngelis, N.T. 16-31). No one, except those in school, gets more than 3½ to 4 hours per day. If one factors out those programs which are not considered beneficial, the average drops to about fifteen minutes per day. (Thurman, N.T. 14-60).[25] Some residents receive no programming due to their extreme hyperactivity, medical problems, or their own refusal of treatment. (DeAngelis, N.T. 16-32; Cooper, N.T. 29-46). Some individuals have not been accepted into occupational therapy, since only group programs are available and they require individual attention. Some Pennhurst residents have been dropped from existing programs due to lack of progress and motivation. The record indicates that the residents at Pennhurst are made to fit into existing programs, and that the programs are not altered to fit the needs of the individuals.

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[25] For example, the programming for residents on Unit 8, the unit in which the most aggressive residents reside, includes several hours per day during which the residents watch TV. Mr. Pirmann the Director of the unit, testified that this was to increase the residents' attention span and to teach them to sit and tolerate the presence of others. (N.T. 19-104, 19-105). "Programming" such as this appears to be primarily for the convenience of the staff, rather than for the benefit of the residents. (Thurman, N.T. 14-68).

Further, it appears that an individual's motivation and not his or her needs determine whether the resident continues with the program. (Hare, N.T. 8-180, 8-181).[26]

Residents are referred to special programs at Pennhurst, but often, due to staff shortages, placements are not made. (DeAngelis, N.T. 16-40, 16-41). Almost every service offered at Pennhurst has a long waiting list. (Foster, Deposition at 42). For example, as of April 15, 1977, there were 511 residents on the referral list for occupational therapy. (Hilker, N.T. 20-43). While 50-60 Pennhurst residents have wheelchairs which have been individually adapted to meet the individual's needs, 75-100 residents need such adaptions. (Fekula, N.T. 20-99). The consequences for the resident not having his or her wheelchair adapted are especially grave, including:

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[26] George Sorotos, a name plaintiff, was enrolled in speech therapy at the end of 1972. At that time, he was unable to communicate, and his program was designed to develop his communicative skills. Though initially he made progress, he soon plateaued. In August, 1973, he was switched to a manual communication program. This continued for six months, again with some initial success. During each program, he was self abusive, which the staff attributed to frustration. He was never able to use these skills for communication. George Sorotos was terminated from all speech activity because the director of the speech and hearing department determined that her time would be better spent with other residents with whom she could accomplish more. (Riggott, N.T. 20-160 to 20-164). Thus, since George Sorotos did not respond well and was self abusive, he was denied speech therapy, a skill essential for his habilitation.

Similarly, plaintiff Terri Lee Halderman was initially included in speech therapy, but because of abusive tendencies, both to herself and to others, she was dropped from the program. (*Id.*, N.T. 20-164 to 20-166).

(1) loss of vital functions; (2) severe muscular contractions; and (3) loss of ability to be programmed. (*Id.*, N.T. 20-101). While over 300 residents at the institution have hearing impairments, only 51 have been fitted with hearing aids. There are 106 residents on the waiting list for speech therapy, and nearly every resident at Pennhurst could benefit from some type of communication programming. (Riggot, N.T. 20-155).[27] Three to four hundred residents presently need physical therapy to prevent physical deterioration, however, only 143 are receiving this therapy. (Rossi, Deposition at 12, 22).[28]

Pennhurst has established a communication center for 22 non-verbal individuals, but the institution has approximately 300 non-verbal residents. In theory, the residents in the communication center spend their day in classes learning signing (i.e., sign language skills), academics, and self-care skills. However, when there is only minimal staff coverage, classes are not offered since the staff is totally occupied with custodial tasks. During the month of April, 1977, there were 5 days during which there was minimal coverage on the first shift (7:00 a.m.-4:00

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[27] Some residents have been on the waiting list for at least 3 1/2 years. (Nelson, N.T. 21-27).

[28] Pennhurst does an especially inadequate job for those with motor disabilities. Dr. Lancaster-Gaye, an expert in, among other things, the management of services for severely disabled persons (N.T. 4-69), toured the institution in March, 1977 and reported that young retarded individuals who suffered from cerebral palsy were sitting on the floor in positions which would lead to physical deterioration. He stated that these individuals were receiving little physical therapy and that without such therapy, the muscles in the limbs of these youths would contract and become useless. (N.T. 4-74, 4-75).

p.m.); 25 days of minimal coverage on the second shift (4:00 p.m.-11:00 p.m.); and thirty days of minimal coverage on the third shift (11:00 p.m.-7:00 a.m.)—on five of these days during the third shift, there was less than minimum staff coverage. (Nelson, N.T. 21-23, 21-24).

Not only is the programming at Pennhurst inadequate to meet minimum professional standards (Rice, Deposition at 179, 180), but so are the evaluations performed on the residents to determine what is required to adequately habilitate the individual. None of the residents at Pennhurst had a full multi-discipline assessment as of January, 1977. (PARC Exhibit 53; Flueck, N.T. 4-9). Twenty and six-tenths percent of the residents have not received a limited multi-discipline assessment since January, 1975, and those assessments which have been made are generally limited to phychological, speech and hearing skills and are rarely concerned with vocational or self-care skills. (Hare, N.T. 8-165, 8-166). Proper habilitation cannot be provided to retarded persons unless those responsible for providing such programs are aware of the individual's needs.

Defendants have not made "full exit plans," *i.e.*, plans delineating: (1) a place for each individual to live outside of Pennhurst; (2) the daily activity necessary for each individual living outside Pennhurst; (3) necessary support services; and (4) the person who would be responsible for any Pennhurst resident.[29] Such plans are

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[29] Sixty and eight-tenths percent of the residents had no mention of the community or of an exit plan in their files, and those that had some indication that the individual's eventual exit from

very important in planning for the resident's eventual return to the community from the institution.

Defendants have also failed to make full "program plans," *i.e.*, plans containing: (1) identification of long and short term goals; (2) specification of the conditions under which the individual might achieve these goals; and (3) specification of the criteria to evaluate the individual's mastery of the goals, for Pennhurst residents.[30]

The record keeping at Pennhurst is also below acceptable minimum standards. (Clements, N.T. 2-22). Adequate record keeping is essential for proper habilitation of the residents.[31] Without such records, the staff will not know what the individual is already able to do, what type of care he or she should be receiving, and how to evaluate progress made by the individual. (*Id.*)

Pennsylvania's immediate plans for Pennhurst call for a reduction of the population at the institution to 850[32]

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the institution had been considered, never specified the type of placement which would be required nor who would be responsible for the individual. (Hare, N.T.8-167).

[30] Twenty-eight and nine-tenths percent had no program plan. Those that did have some plan rarely had a precise statement of goals and objectives. (Hare, N.T. 8-166).

[31] An individual's record should contain: (1) a current comprehensive evaluation of the individual; (2) a list of short and long term goals for the individual; (3) a specific plan outlining the procedures to accomplish these goals. The program should also provide for on-going monitoring, periodic re-evaluations of the individual, and periodic modifications of the objectives and procedures to reflect the findings of the re-evaluations. (Roos, N.T. 1-115, 1-116).

[32] Decreasing the population to 850 is contingent on an increase in funds appropriated by the Pennsylvania legislature,

and to provide, by July 1, 1978, 2½ hours of programming per resident per day. Dr. Rice, the Commissioner of Mental Retardation for Southeast Pennsylvania felt that such programming would fulfill the minimum requirements to qualify for medical assistance (*i.e.*, federal financing). However, he knew of no other set of standards which would consider this level of programming minimally acceptable, and personally did not feel that it was adequate. (N.T. 27-28). As a matter of practice, the Department of Mental Retardation for the Southeast Region will not approve a community living arrangement for a mentally retarded individual unless it provides for programming of at least five and one-half hours per day. (Rice, N.T. 27-80).

C. *Restraints at Pennhurst*

At Pennhurst, restraints are used as control measures in lieu of adequate staffing.[33] (Clements, N.T. 2-82, 2-84; Roos, N.T. 1-135; Sprague, N.T. 3-44; Hersh, N.T. 13-153, Foster, Deposition at 81). This is not to say that restraints should never be used in the habilitation of the retarded. When an individual's aggressive behavior interferes with his or her ability to take advantage of other programming which the individual should receive, or poses a physical threat to him or herself and others it may be

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along with an ambitious placement program—unfortunately much of this placement is from one institution (Pennhurst) to other institutions rather than to the community.

[33] Restraints can be either physical or chemical. The physical restraints range from placing the individual into a seclusion room to binding the person's hands or ankles with muffs or poseys, and binding the individual to a bed or a chair. Chemical restraints are usually psychotraupic (*i.e.*, tranquilizing) drugs.

proper to restrain that person. Soon, it is hoped, once the individual has benefited from the other programming, the restraint will not be needed. (Clements, N.T. 2-86). It is generally conceded that most, if not all, outbursts of violence by the retarded can be prevented by adequate programming.

Seclusion rooms[34] have been used to punish aggressive behavior. One eighteen year old individual spent six consecutive days in seclusion in 1974 for assaulting a Down's Syndrome resident. (Lowrie, N.T. 5-6, 5-7). In 1975, a committee was formed to investigate the use of seclusion rooms at Pennhurst. It recommended that seclusion rooms, if they were to be used at all, should be limited to medical emergencies and should not be utilized for punishment. (Lowrie, N.T. 5-5). Seclusion rooms are still in use at Pennhurst (M. Conley, N.T. 16-150; Boyle, N.T. 17-72, 17-73; L. Miller, N.T. 77-102; Malone, N.T. 17-140, 17-141; Lowrie, N.T. 5-71), though the incidence of their use is less than it was in years past. There is now a policy that seclusion rooms be used only for medical emergency, when a resident becomes extremely abusive, and no other alternative will control the individual. One-to-one interaction with staff members is often effective in calming the resident and stopping this maladaptive behavior. However, since normally the wards are, at best, minimally staffed, there frequently is

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[34] The seclusion rooms at Pennhurst are small rooms generally with one window and one door. The walls are masonry, the floors either tile or terrazzo—both hard surfaces. None of the rooms are padded. Many have exposed radiators, and other potentials for danger to the resident placed within it. (Youngberg, Deposition at 69; Lowrie, N.T. 4-183 to 4-190).

not a staff person who can be spared to participate in this intensive interaction. (Lowrie, N.T. 5-9; Miller, N.T. 17-122). Thus, seclusion is often necessary only because there is insufficient staff. (Lowrie, N.T. 4-131).[35]

Often physical restraints are also used due to staff shortages. An extreme example is a female resident who, during the month of June, 1976, was in a physical restraint for 651 hours 5 minutes; for the month of August, 1976, was in physical restraints for 720 hours; during September, 1976, was in physical restraints for 674 hours 20 minutes; and during the month of October, 1976, was in physical restraints for 647 hours 5 minutes. (Matthews, Deposition at 64-68). This resident was extremely self-destructive—she totally blinded herself. She was not enrolled in occupational therapy until early 1977. Once initiated, her programming has apparently been quite successful, and she is now able to be out of restraints for as much as four hours per day. (Foster, N.T. 23-43). Had this programming been initiated earlier, her self-inflicted injuries might have been avoided or at least lessened.

Physical restraints are potentially physically harmful and can create conditions in which physical injuries are

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[35] One young male resident had a tendency to run away from the institution. When he was given one-to-one interaction with staff, he would not attempt to run away. When the program of one-to-one interaction was dropped due to staff shortages, he again began running away. He was warned that he would be put on a locked ward if his behavior continued, and he became abusive to staff. As a result of this behavior, he was put into a seclusion room. (Foster, N.T. 22-44 to 22-46).

more likely to occur (Clements, N.T. 2-87; Hirst, N.T. 7-131; Roos, N.T. 1-166),[36] and prevent residents from learning or exercising self-care skills. (Clements, N.T. 2-87).

Psychotraupic drugs at Pennhurst are often used for control and not for treatment, and the rate of drug use on some of the units is extraordinarily high. (Hersh, N.T. 13-153).[37] Dr. Sprague, an expert in psychopharmacology,[38] testifying on behalf of the United States, conducted a survey of 39 residents at Pennhurst, a group which he considered to be statistically representative of the residents at Pennhurst. He found that 51% of the group were receiving psychotraupic drugs, 35% of the group were receiving anti-convulsant medication, and 40% were receiving two or more psychotraupic drugs at one time. (N.T. 3-36). In comparison with similar instiutions throughout the country, Dr. Sprague stated that

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[36] In 1972, an eleven year old child strangled to death when tied to a chair in "soft" restraints. (Lowrie, N.T. 4-133—4-135).

[37] Until March, 1977, Pennhurst had no written policy against the use of PRN orders (*"pro re nata"* or *"as needed"*) for restraints or seclusion. In its most extreme form, a doctor would prescribe a restraint or seclusion for a patient to be administered in the discretion of a direct care aide or a nurse. (Boyle, N.T. 17-93, 17-94). At best, the doctor would be called prior to administration of the drug, but he or she seldom personally visited the resident either before or shortly after the medication or physical restraint was administered. (Boyle Deposition at 22).

[38] "Psychopharmacology" is the area of study dealing with prescription medicines that are prescribed for mind alteration for behavior control. (Sprague, N.T. 3-12, 3-13).

these percentages were very high, though he said that some institutions administer comparable levels.[39]

Dr. Sprague also found that Pennhurst residents on drugs were inadequately monitored. Without monitoring, one cannot determine whether the drug has been effective and whether it should be continued. Dr. Sprague found that in only 29% of the cases in which a drug was administered were its effects on the individual evaluated. (N.T. 3-45). He further testified that the drug practice at Pennhurst does not meet minimally professional standards and is physically hazardous to the residents. (N.T. 3-55, 3-90).

One of the side effects of the use of psychotraupic medication is that it may make the individual receiving it lethargic—so much so that the recipient may fall asleep during school, or during other times when activities and/or programming are being attempted. (Lowrie, N.T. 5-22). Other hazardous side effects of these drugs include hypersensitivity to sunlight; ataxia (inability to maintain balance and gait); and gingival hyperplasia (gum tissue condition marked by inflammation, bleeding and increased growth). (Hedson, Deposition at 59-61). Thus, the administration of such drugs actually impedes the habilitation of the resident, especially when used as a control rather than a habilitation device.

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[39] Dr. Sprague testified that at a state institution in Georgia serving the most severely retarded individuals, only 25% of the residents were on drugs. (N.T. 3-38).

D. *Deterioration and Abuse of the Residents at Pennhurst*

The physical environment at Pennhurst is hazardous to the residents, both physically and psychologically. (Clements, N.T. 2-59). There is often excrement and urine on ward floors (Roos, N.T. 1-158; Smith, Deposition at 41), and the living areas do not meet minimal professional standards for cleanliness. (Youngberg, Deposition at 24). Outbreaks of pinworms and infectious disease are common (M. Conley, N.T. 16-193; Lowrie, N.T. 4-153; Hedson, Deposition at 122). As Superintendent Youngberg noted:

> There is not adequate space for [the residents. The living areas do] not provide privacy for those persons who can handle privacy. There does not seem to be adequate activity areas or program areas or even general activity areas within the general living area or even adequate activity program areas away from the home living area. (Deposition at 23).

The environment at Pennhurst is not only not conducive to learning new skills, but it is so poor that it contributes to losing skills already learned.[40] (Clements, N.T. 2-59). For example, Pennhurst has a toilet training program, but one who has successfully completed the program may not be able to practice the newly learned skill, and is therefore likely to lose it. (Clement, N.T.

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[40] A survey conducted by Dr. Betty Hare revealed that 34% of the individuals in the group surveyed had some notation of regression in their records. (PARC Exhibit 53, Hare, N.T. 8-167). Those "skills" which are learned at Pennhurst are often antisocial. (Roos, N.T. 1-139; Clements, N.T. 2-84).

2-36, 2-37). Moreover, most toilets areas do not have towels, soap or toilet paper,[41] and the bathroom facilities are often filthy and in a state of disrepair. Obnoxious odors and excessive noise permeate the atmosphere at Pennhurst. Such conditions are not conducive to habilitation. (Dybwad, N.T. 7-52). Moreover, the noise level in the day rooms is often so high that many residents simply stop speaking. (Clements, N.T. 2-59).

Meals are eaten in a large group setting, Staff supervision is at a minimum, and residents are often free to steal food from other residents—which results in some residents not getting enough to eat. (Clements, N.T. 2-73). Obviously, diet control in such an environment is almost impossible.

Injuries to residents by other residents, and through self-abuse, are common. For example, on January 8, 1975, one individual bit off three-quarters of the earlobe and part of the outer ear of another resident while the second resident was asleep. (Matthews, Deposition at 83). About this same period, one resident pushed a second to the floor, resulting in the death of the second resident. (Barton, Deposition at 67, 68). Such resident abuse of residents continues. In January, 1977 alone, there were 833 minor and 25 major injuries reported.[42] (Youngberg, Deposition at 83).

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[41] Direct care aides testified that there was no soap or towels in the toilet areas because when placed there, the residents stuffed them down the toilets. (Roy, N.T. 15-108). These same aides also testified, however, that no programming had been conducted to try to negate this behavior. (*Id.*, N.T. 15-127).

[42] This figure includes injuries due to self-abuse and to accidents.

In addition, there is some staff abuse of residents. In 1976, one resident was raped by a staff person (Ruddick, N.T. 3-115 to 3-117); one resident was badly bruised when a staff person hit him with a set of keys (Barton, Deposition at 40); another resident was thrown several feet across a room by a staff person (Ruddick, N.T. 3-113; Caranfa, N.T. 12-79); and one resident was hit by a staff person with a shackle belt (Bowman, N.T. 13-83; Pirmann, N.T. 19-94). On each occasion, an investigation was conducted and the staff person responsible was suspended and/or terminated (Ruddick, N.T. 3-114; Bowman, N.T. 13-82, 13-83, 13-84; Pirmann, N.T. 19-94).

Many of the residents have suffered physical deterioration and intellectual and behavioral regression during their residency at Pennhurst. Terri Lee Halderman, the original plaintiff in this action, was admitted to Pennhurst in 1966 when she was twelve years of age. During her eleven years at Pennhurst, as a result of attacks and accidents, she has lost several teeth and suffered a fractured jaw, fractured fingers, a fractured toe and numerous lacerations, cuts, scratches and bites.[43] Prior to her admission to Pennhurst, Terri Lee could say "dadda", "mamma", "noynoy" (no), "baba" (goodby) and "nana" (grandmother). She no longer speaks. (Halderman, N.T. 9-69, 9-71, 9-78, 9-87, 9-88).

Plaintiff Charles Dinolfy was admitted to Pennhurst when he was nine years old; he is now forty-five and has resided at the institution continually except for short stays

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[43] Terri Lee Halderman's medical records contain a listing of over forty reported injuries.

at White Haven State School and Hospital. (Hunsicker, N.T. 9-39). Dorothy Hunsicker, his sister, testified that whenever she or her family visited him, Mr. Dinolfy had some type of bandage on. (*Id.*) Twenty-six years ago while at Pennhurst, Mr. Dinolfy lost an eye. A Pennhurst physician told Ms. Hunsicker that Mr. Dinolfy slipped while taking a shower, and hit the spigot with his eye. The sight in his remaining eye has been impaired due to injury. (*Id.*, N.T. 9-46, 9-47). He has only a few teeth remaining and his nose has been battered. (*Id.*, N.T. 9-41).

Plaintiffs Robert and Theresa Sobetsky were admitted to Pennhurst on November 29, 1971.[44] They were placed on extremely overcrowded wards where beds were placed in the aisles. Robert was never assigned to a particular bed. (Sobetsky, N.T. 9-145, 9-146). During his residency at Pennhurst, Robert Sobetsky suffered from bruises, bites, scratches, welts and he smelled of urine. (*Id.*, N.T. 9-147, 9-148). His record shows a number of reported injuries, some of which, though labeled minor injuries, represented bruises that were three to five inches in length. (*Id.*, 9-151, 9-152). Theresa also suffered such injuries. (*Id.*, N.T. 9-148).

Plaintiff Robert Hight, born in 1965, was admitted to Pennhurst in September, 1974. He was placed on a ward with forty-five other residents. His parents visited him two and one-half weeks after his admission and found that he was badly bruised, his mouth was cut, he

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[44] Since January, 1976, they have been residing at Woodhaven, a Pennsylvania institution for the mentally retarded run by Temple University.

was heavily drugged and did not recognize his mother. On this visit, the Hights observed twenty-five residents walking the ward naked, others were only partially dressed. During this short period of time, Robert had lost skills that he had possessed prior to his admission. The Hights promptly removed Robert from the institution, Mrs. Hight commenting that she "wouldn't leave a dog in conditions like that." (N.T. 11-22, 11-23).

Plaintiff George Sorotos entered Pennhurst in 1970 at the age of seven. In the seven years that George has been at Pennhurst his former foster mother, Marion Caranfa,[45] testified that in her weekly visits to Pennhurst there have been only four occasions when George was not injured. (N.T. 12-63). During this period, he has suffered from numerous reported injuries, including bites, scratches, black eyes and loss of teeth. In addition, Mrs. Caranfa testified that she recently observed what appeared to be cigarette burns on George's chest. (N.T. 12-65).

Plaintiffs Larry and Kenny Taylor entered Pennhurst on February 28, 1961. In the early 1970's, Mrs. Taylor questioned the staff about the medication being given to Larry. He was very lethargic, falling asleep at school and barely able to walk. (Taylor, N.T. 13-24). The physician in charge of Larry's unit, checked Larry's medical record and found that he was on dilantin, a drug used

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[45]The Caranfas were made George Sorotos' foster parents when he was six weeks old. Sometime after he entered Pennhurst, the agency which had supervision over George removed them as his foster parents. They still consider him as one of their family and have continued their visits. (Caranfa, N.T. 12-62, 12-105).

to control epileptic seizures. Mrs. Taylor testified that Larry had had only one seizure that she knew of and that had been when he was a baby. Larry was removed from dilantin and placed on mellaril, a psychotraupic drug. This, too, made him lethargic. (*Id.*, N.T. 13-26 to 13-28). Larry and Kenny were transferred to Woodhaven in 1975 where Mrs. Taylor testified that Larry does not receive any psychotraupic medication, and is able to walk independently. (*Id.*, N.T. 13-32). Larry was often injured while at Pennhurst; on one occasion, he was hospitalized for two weeks because of head and face injuries he received as a result of a beating by another resident. (*Id.*, N.T. 13-30). Kenny, too, suffered serious injuries while at Pennhurst. (*Id.*, 13-29).

Plaintiff Nancy Beth Bowman entered Pennhurst at the age of ten in 1961. She was placed on a large ward which had sixty-five residents and often only two child-care aides in attendance. (Bowman, N.T. 13-71; Pirmann, N.T. 19-89). During her residency at Pennhurst she developed maladaptive behavior, *i.e.*, biting and pushing. (Bowman, *Id.*) As a result of this maladaptive behavior she had been placed in seclusion for days at a time. (*Id.*, N.T. 13-71). While at Pennhurst, she has lost teeth, been badly bruised and has been abused by the staff. (*Id.*, N.T. 13-72, 13-73, 13-81). When asked about her present physical condition, Nancy Beth's mother replied, "Nancy Beth will be scarred for the rest of her life." (*Id.*, N.T. 13-94).

Plaintiff Linda Taub, who is blind in addition to being retarded, was admitted to Pennhurst in 1966 at the age of fifteen. According to her father, during her

nine year residency at Pennhurst Linda received only custodial care and she experienced regression rather than growth. (Taub, N.T. 2-170). Time on the ward was spent sitting and rocking, with few activities. (*Id.*, N.T. 2-155). During one of their visits in 1968, Linda's parents found Linda, a person capable of walking, strapped to a wheelchair by a straightjacket. A staff member explained that by strapping her into the chair, they would know exactly where Linda was. (*Id.*, N.T. 2-152, 2-153). While at the institution, Linda was badly bruised and scarred. (*Id.*, N.T. 2-164).

E. *Voluntariness*

Approximately 21 of the 45 living units at Pennhurst are locked (Matthews, Deposition at 34) to prevent individuals from leaving their living units. (Uphold, Deposition at 139). Those individuals over the age of 18 who have been "voluntarily" admitted to Pennhurst are theoretically free to leave the institution at any time. (Allen, N.T. 21-185). Those admitted on the petition of their parents are informed by their caseworker when they reach the age of 18 that they do not have to remain at Pennhurst. If the residents state that they wish to leave the institution and the staff determines that there is no place for them in the community, or believes that the individuals are not ready to go into the community, the staff will petition the courts to have the individuals committed to the institution by a court. (*Id.*, N.T. 21-186, 21-205). Furthermore, those residents who either do not understand their alternatives, or are physically unable to indicate that they wish to leave Pennhurst, will be deemed to have consented to their continued place-

ment at the institution. (*Id.*, N.T. 21-210). Thus, the notion of voluntariness in connection with admission as well as in connection with the right to leave Pennhurst is an illusory concept. Few if any residents now have, nor did they have at the time of their admission, any adequate alternative to their institutionalization. As a practical matter, Pennhurst was and is their only alternative.[46]

F. *Community Services in the Five County Area*

Since the early 1960's there has been a distinct humanistic renaissance, replete with the acceptance of the theory of normalization for the habilitation of the retarded. Mason & Menolascino, *supra* note 6, at 136. The principles of normalization are an outgrowth of studies showing that those in large institutions suffered from apathy, stunted growth and loss in I.Q., and that the smaller the living unit on which the retarded individual lived, the higher the level of behavioral functioning shown by the individual. (Roos, N.T. 1-96 to 1-104). Under the principles of normalization, the retarded individual is treated as much like the non-retarded person as possible. (*Id.*, N.T. 1-106, 1-107). The basic tenet of normalization is that a person responds according to the way he or she is treated. (Glen, N.T. 5-186, 5-187). The thrust of habilitation through normalization is the remediation of the delayed learning process so as to develop the maxi-

[46] Nearly all the parents of Pennhurst residents who testified stated that they placed their children in Pennhurst only as a last resort, and had there been community facilities or aid programs, their children would not have been placed at Pennhurst. (Sobetsky, N.T. 9-142; Hight, N.T. 11-21).

mum growth potential by the acquisition of self-help, language, personal, social, educational, vocational and recreation skills. Mason & Menolascino, *supra* note 6, at 139-140. The older theories of habilitating the retarded stressed protecting the individual, and were characterized by little expectation of growth. Given this lack of expectation, the individual rarely exhibited growth. However, once removed from depressing, restrictive routines, the retarded have been able to accomplish a great deal. (Dybwad, N.T. 7-160).[47]

The environment at Pennhurst is not conducive to normalization. It does not reflect society. It is separate and isolated from society and represents group rather than family living. (Hirst, N.T. 7-124). The principles of normalization have been accepted by the administration of Pennhurst and by the Department of Public Welfare, which is responsible for the administration of programs for the retarded in the five county area (Youngberg, N.T. 22-171; Rice, N.T. 26-43 to 26-45; Bilyew, N.T. 24-13; Hirst, N.T. 7-120), and the current intention of the Department of Public Welfare is to transfer all residents from Pennhurst by the early 1980's. (Rice, N.T. 28-48).

The five county area (Bucks, Chester, Delaware, Montgomery and Philadelphia) has some community

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[47] Mrs. Grace Auerback testified concerning the changes she has observed in her son, Sid, since his transfer from Pennhurst into a community home in 1973. While at Pennhurst, he was subdued and never talked; now, she testified, you cannot stop him. He is now able to cook, work and keep his own bank account. She testified that Sid had learned more in the last 3 1/2 years while in the community than he had in the 38 years that he had resided at Pennhurst. (N.T. 8-47, 8-48, 8-49, 8-51).

facilities providing for the education, training and care of the retarded covering all ages of retardation, including the profoundly retarded with multiple handicaps. (Girardeau, N.T. 4-140, 4-141). These community facilities have been an outgrowth of the acceptance of the principle of normalization and the rejection of institutions such as Pennhurst in connection with the habilitation of the retarded.

Many individuals now living at Pennhurst could be moved immediately into the community and would be able to cope with little or no supervision. (Settle, N.T. 6-126; Hirst, N.T. 7-116). All the parties in this litigation are in agreement that given appropriate community facilities, all the residents at Pennhurst, even the most profoundly retarded with multiple handicaps, should be living in the community. (Dybwad, N.T. 7-68).

The primary limiting factor in the transfer of Pennhurst residents to community facilities has been the failure of the Commonwealth and its subdivisions to provide sufficient living units, vocational and day care facilities and other support services at the community level. Since fiscal year 1972, only 186 Pennhurst residents have been transferred from the institution directly into community living units (Bilyew, N.T. 24-50); although 176 others were transferred from Pennhurst to other institutions during 1974 and 1975. (Clark, N.T. 21-170).

In November, 1970, Act 256 was signed by the Governor of Pennsylvania. This legislation appropriated twenty-one million dollars for the purpose of planning, designing and constructing community facilities which would enable 900 Pennhurst residents to be transferred

to the community. In 1971, the McDowell report was prepared at a cost of $68,000. It detailed the programs and services needed to support the 900 Pennhurst residents in the community and provided a blueprint for the implementation of the Act. (Samuels, N.T. 23-9, 23-10, 23-55). Though seven years have passed since the Act was signed, few of the facilities have become operational. The Department of Public Welfare now expects this program to be completed by 1980. (*Id.*, N.T. 23-44). Over eighteen million dollars of this fund remains unspent but is allocated to building these facilities. (Stipulation, N.T. 7-97). As of April 25, 1977, however, only 37 Pennhurst residents have directly benefited from the Act. (Samuels, N.T. 23-80).

Comparable facilities in the community are generally less expensive than large isolated state institutions. Services can be purchased at regular rates, rather than at rates which must be paid to attract individuals to work in a setting like Pennhurst. (Conley, N.T. 11-107). The cost of running Pennhurst in 1976 was $27.8 million dollars, or $60 per resident per day. (*Id.*, N.T. 12-28). This does not include the fair rental value of the buildings at Pennhurst (estimated at $3-$4 per day). (*Id.*, N.T. 11-114). The statewide cost of community living arrangements in Pennsylvania for 1976 was $17.64 per individual per day. (PARC Exhibit 63, 64). Program services, which 1/3 of mentally retarded individuals would need, average approximately $10 per individual per day. (Conley, N.T. 11-116, 11-117). Moreover, keeping the retarded individual in the community makes it possible for him or her to get employment. Eighty-five percent of the mentally retarded can be employed,

though not all are capable of competitive employment. (Settle, N.T. 7-4). The lifetime earnings of a mildly retarded individual often exceeds $500,000. (Conley, N.T. 12-21). For those with an I.Q. between 25 and 50, 45% of men and 12% of women earn about 20% of the average wage. (*Id.*, N.T. 12-31). When the retarded can work, the amount of financial support which society must provide decreases and the individuals may benefit society with the taxes they pay. Furthermore, the investment per individual at Pennhurst is primarily for warehousing and not for the individual's well-being or future planning, as is the case with community facilities. (*Id.*, N.T. 11-23, 11-24).

G. *County Participation*

The counties presently have a financial incentive to send their retarded to Pennhurst rather than provide them with habilitation within the community. When a retarded individual is placed in a state institution, such as Pennhurst, the Commonwealth pays 100% of the costs incurred in the habilitation of the individual. However, if the individual receives services within the community, the county must provide 10% of the funds necessary to provide some of the services.

Every mentally retarded individual within the Commonwealth is assigned to a Base Service Unit (BSU) which is the county unit responsible for arranging community and institutional placements and for coordinating services for the individual. (Rice, N.T. 25-67). Pennhurst residents are assigned to a BSU either on the basis of where they resided prior to admission to the institution, or where their family presently resides. Almost all of

the parents of Pennhurst residents who testified stated that they had little or no contact with their child's BSU. (Hunsicker, N.T. 9-49; Taylor, N.T. 13-30). The BSU's are invited to attend their residents' annual program review, but almost never do. (Roy, N.T. 15-134; Hare, N.T. 8-176). The BSU's often fail to investigate the least restrictive alternative for the retarded individual under their charge. Placement at Pennhurst is often the only alternative presented to the committing judge at court commitment proceedings.[48]

The BSU's have been doing little to prepare Pennhurst residents to leave Pennhurst. Although the Pennsylvania Department of Public Welfare, Pennhurst staff and county officials are in complete agreement that the residents of Pennhurst should be transferred as soon as practicable to appropriate community facilities, apparently no one has taken the initiative to accomplish this objective. (Hersh, N.T. 13-136).

The five county defendants are not in compliance with the Commonwealth's Community Living Arrangement (CLA) policy that at least 50% of the residents for these living facilities must be drawn from institutions. In contrast to other regions in the state, the counties which Pennhurst serves have a lower percentage of CLA residents drawn from institutions than from the community. (Knowlton, Deposition at 52).

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[48] One Philadelphia BSU made a referral to Pennhurst for a child it had decided needed a structured environment with one-to-one interaction, even though it knew that the individual would not receive such individualized treatment at Pennhurst. (Cooper, N.T. 29-74).

IV. *The Merits*

This case concerns the constitutional and statutory rights of retarded persons institutionalized at Pennhurst. Our discussion herein pertains to the retarded, individuals who, because of circumstances beyond their control, are unable to function at the same educational and behavioral levels as the rest of society. It concerns solely the retarded and not persons who are mentally or emotionally ill. These are individuals who have not broken any laws, carry no contagious disease and are not in any way a danger to society. If anyone is in need of training, education and care, they are. At issue is whether the Commonwealth's system of incarcerating the retarded in an institution known as Pennhurst in any way violates their constitutional or statutory rights.

Having concluded the trial phase of the liability portion of this litigation, it has become apparent that by and large the parties share the same goals: all desire to improve the education, training and care provided the retarded in Pennsylvania and believe that Pennhurst should be closed and that all the residents should be educated, trained and cared for in the community. All agree that institutions such as Pennhurst are inappropriate and inadequate for the habilitation of the retarded. Defendants agree with plaintiffs' contention that the habilitation provided Pennhurst residents does not meet minimally acceptable professional standards. The Commonwealth in recent years has been attempting to upgrade Pennhurst and the education, training and care provided therein to its retarded residents. Moreover, the Pennsylvania Department of Public Welfare's current plans call for the

transfer of all Pennhurst residents from the institution into the community (though perhaps temporarily into other institutions) by the early 1980's. Defendants contend, however, that they are neither constitutionally nor statutorily mandated to make these transfers or to upgrade the care, education and training provided at Pennhurst. It is their position that no constitutional or statutory rights have been violated. We disagree. Moreover, defendants' plans to upgrade and eventually close Pennhurst have little, if any, bearing on the issue of whether the statutory or constitutional rights of Pennhurst's retarded residents have been, or are being, violated. As the court in *Welsch v. Likins,* 373 F. Supp. 487, 498 (D. Mn. 1974), *aff'd in part, vacated and remanded in part,* 550 F. 2d 1122 (8th Cir. 1977), stated:

> good faith is not at issue here. "[R]ather the issue is of the protection of the constitutional rights" of the residents. . . . It does not suffice, therefore, to show that conditions have been upgraded at [the institution], that the situation will continue to improve in the future, and that even more achievements would be forthcoming were it not for the restrictions imposed by the legislature. It is the Court's duty, under the Constitution, to assure that every resident of [the institution] receives at least minimally adequate care and treatment consonant with the full and true meaning of the due process clause.

A. *Constitutional Right to Minimally Adequate Habilitation*

The Supreme Court has not as yet stated that the retarded have a constitutional right to habilitation. It has,

however, discussed the right to treatment of the mentally ill. *O'Connor v. Donaldson,* 422 U.S. 563 (1975). Donaldson had been civilly committed to a state mental hospital in 1957 and had remained there involuntarily for nearly fifteen years. Repeatedly, but without success, he had demanded his release, contending that he was neither dangerous nor mentally ill, and that even if he were mentally ill, that he should be released since the hospital had not provided him with treatment for his illness. The *Donaldson* holding is very narrow: "a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." *Id.* at 576.

Donaldson allegedly was suffering from "paranoid schizophrenia", *id.* at 565, and was not retarded. When dealing with the retarded, the concern is for "habilitation" rather than for "treatment".[49]

> The use of the concept "habilitation" instead of "treatment" in the context of mental retardation reflects an awareness that "mental illness" is not

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[49] Often, those courts which have dealt with mentally ill and retarded individuals have blurred the issues involved. The "right to treatment" is frequently used in conjunction with the retarded, when in fact, these individuals are not in need of medical treatment, but of education and training. In part, this blurring is due to the fact that some of the cases involved several facilities, some for the retarded and some for the mentally ill, *see, e.g., Wyatt v. Stickney,* 325 F. Supp. 781 (M.D. Ala. 1971) (mentally ill), 344 F. Supp. 387 (M.D. Ala. 1972) (retarded), and others involved a single facility serving both retarded and mentally ill individuals, *see e.g., Davis v. Watkins,* 384 F. Supp. 1196 (N.D. Ohio 1974).

> synonymous with "mental retardation." Mental illness concerns an inability to cope with one's environment regardless of intellectual level. Mental illness can occur at any stage of life while mental retardation is considered to be a developmental disability beginning in the early years.

Mason & Menolascino, *supra* note 6, at 147 n. 72 (1976). Although we are convinced that the concept of "habilitation" for the retarded and "treatment" for the mentally and emotionally ill are separate and distinct concepts which should never be confused, in dealing with the question of the right of the retarded to adequate habilitation one must consider, to the extent applicable, those cases which deal with the right to treatment of the mentally ill.[50]

A great deal of scholarly and judicial attention has been focused on the question of a constitutional right to treatment and habilitation since Dr. Morton Birnbaum's seminal work, *The Right to Treatment,* 46 A.B.A. J. 499 (1960).[51]

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[50] Of course, as the Supreme Court has noted, "careful attention must be paid to the differences between mentally ill and mentally retarded . . . ." *Kremens v. Bartley,* U.S. , 97 S. Ct. 1709, 1718 (1977). However, as one court has noted: "[i]n the context of the right to appropriate care for people civilly confined to public mental institutions, no viable distinction can be made between the mentally ill and the mentally retarded." *Wyatt v. Stickney,* 344 F. Supp. 387, 390 (M.D. Ala. 1972), *aff'd in part, rev'd in part and remanded in part sub nom. Wyatt v. Aderholt,* 503 F.2d 1305 (5th Cir. 1975).

[51] Dr. Birnbaum wrote:

> It is proposed . . . that the courts under their traditional powers to protect the constitutional rights of our citizens be-

Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), was one of the first federal cases to deal with the right to treatment. Rouse had been involuntarily committed to a mental hospital following his acquittal by reason of insanity of a misdemeanor for which the maximum term of imprisonment was one year. Rouse filed a petition for habeas corpus which the district court denied, contending that he had a right to be released if he was not accorded adequate treatment. Although the Circuit Court reversed on the basis of a District of Columbia statute, Chief Judge Bazelon stated that "involuntary confinement without treatment is 'shocking' ", *id.* at 455, and noted that the

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gin to consider the problem of whether or not a person who has been institutionalized solely because he is sufficiently mentally ill to require institutionalization for care and treatment actually does receive adequate medical treatment so that he may regain his health, and therefore his liberty, as soon as possible; that the courts do this by means of recognizing and enforcing the right to treatment; and, that the courts do this, independent of any action by any legislature, as necessary and overdue development of our present concept of due process of law.

46 A.B.A. J. at 503.

See, e.g.: Mason & Menolascino, *supra* note 6; *Developments in the Law—Civil Commitment of the Mentally Ill,* 87 Harv. L. Rev. 1190 (1974); *Herr, Civil Rights. Uncivil Asylums and the Retarded,* 43 Cin. L. Rev. 679 (1974); Drake, *Enforcing the Right to Treatment; Wyatt v. Strickney,* 10 Amer. Crim. L. Rev. 587 (1972); Case Comment, *Wyatt v. Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment,* 86 Harv. L. Rev. 1282 (1973); Note, *The Wyatt Case: Implementation of a Judicial Decree Ordering Institutional Change,* 84 Yale L. J. 1338 (1975); Hoffman and Dunn, *Beyond Rouse and Wyatt: An Administrative-Law Model for Expanding and Implementing the Mental Patient's Right to Treatment,* 61 Va. L. Rev. 297 (1975).

purpose of involuntary hospitalization is treatment and not punishment. *Id.* at 452. He pointed out that a statute which provides for the mandatory commitment of an individual acquitted of a criminal offense by reason of insanity is permissible only because of its "humane therapeutic goals," and concluded that if treatment were not required under the statute, the statute might violate the Due Process, Equal Protection and Cruel and Unusual Punishment Clauses of the Constitution. *Id.* at 453.

Civil commitment entails a "massive curtailment of liberty". *Humphrey v. Cady,* 405 U.S. 504, 509 (1972). The only permissible justifications for committing the mentally ill are: (1) danger to the individual, (2) danger to others, and (3) need for treatment. *Jackson v. Indiana,* 406 U.S. 715, 737 (1972); *Wyatt v. Aderholt,* 503 F.2d 1305, 1312 (5th Cir. 1974). Although this Court entertains serious doubts as to whether retarded individuals should ever be subjected to "commitment", there is no doubt that under the present case law, the only possible justification for committing the retarded to an institution such as Pennhurst is to provide them with habilitation, *i.e.,* education, training and care. Failure to provide adequate habilitation may well mean commitment for the life of the retarded individual. *Welsch v. Likins,* 373 F. Supp. 487, 497 (D. Mn. 1974), *aff'd in part and vacated and remanded in part,* 550 F.2d 1122 (8th Cir. 1977). In fact, at Pennhurst the average residency is twenty-one years.

Moreover, as the Court stated in *Jackson v. Indiana,* 406 U.S. at 738, "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purposes for which the individ-

ual is committed." Since the only justifiable purpose for the commitment of the retarded is habilitation, if habilitation is not provided, the nature of the commitment bears no reasonable relation to its purpose and the individual's due process rights have been violated. *Wyatt v. Aderholt,* 503 F.2d 1305, 1312 (5th Cir. 1974); *Donaldson v. O'Connor,* 493 F.2d 507, 521 (5th Cir. 1974), *vacated,* 422 U.S. 804 (1975).[52]

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[52] As heretofore pointed out, the Supreme Court's decision in *Donaldson* was very narrow; the Court did not pass upon the issue of the right to treatment or habilitation. The Court vacated the Fifth Circuit's broad holding and stated: "[o]f necessity our decision vacating the judgment of the Court of Appeals deprives that court's opinion of precedential effect, leaving this Court's opinion and judgment as the sole law of the case." 422 U.S. 563, 577 n. 12 (1975). Prior to the Supreme Court's decision, the Fifth Circuit rendered a second right to treatment decision which relied heavily on its *Donaldson* opinion, *Wyatt v. Aderholt,* 503 F.2d 1305 (5th Cir. 1974), which like *Donaldson* was authored by Judge Wisdom. At least one commentator suggests "that *Wyatt* is still good law, thus leaving the right to treatment issue where it was before." *"What More": A Constitutional Right to Treatment?* 22 Loyola L. Rev. 373, 383 (1976). In support of this proposition, it should be noted that four days after deciding *Donaldson,* the Supreme Court denied *certiorari* in yet another Fifth Circuit right to treatment case. The Department of Human Resources of the State of *Georgia v. Burnham,* 422 U.S. 1057 (1975). In *Burnham,* the district court had found that there was no constitutional right to treatment. 349 F. Supp. 1335 (N.D. Ga. 1972). The Fifth Circuit reversed on the basis of its *Donaldson* and *Aderholt* decisions. 503 F.2d 1319 (5th Cir. 1974). Even though the Supreme Court had vacated the *Donaldson* decision only four days before, it denied *certiorari* in *Burnham,* apparently allowing *Aderholt,* with its holding of a constitutional right to treatment to remain as the law of the Fifth Circuit.

In *Robinson v. California,* 370 U.S. 660 (1962), the Supreme Court held that incarceration solely on the basis of an individual's status constitutes cruel and unusual punishment. (Robinson was convicted of being a narcotics addict.) As was pointed out in *Welsch:*

> because plaintiffs [retarded individuals] have not been guilty of any criminal offenses against society, treatment is the only constitutionally permissible purpose of their confinement, regardless of procedural protections under the governing civil commitment statute. . . . This argument rests upon the Eighth and Fourteenth Amendments, relying principally upon the Supreme Court's decision in *Robinson v. California.* . . . The plaintiffs in the instant action are not criminals; they are victims of uncontrollable "status."
>
> If they are subject to "detention for mere illness —without a curative program," . . . plaintiffs will be within the ambit of the *Robinson* proscription.

373 F. Supp. at 496. Thus, commitment of the retarded can withstand constitutional scrutiny only when it is coupled with minimally adequate habilitation. *See United States v. Jackson,* 553 F. 2d 109, 119 (D.C. Cir. 1976).

Of the federal courts which have considered the right to habilitation issue in connection with involuntarily committed retarded individuals and the right to treatment of involuntarily committed mentally or emotionally ill individuals, only two reported cases have been called to our attention which denied the existence of such a constitutional right: *Burnham v. Department of Public Health of the State of Georgia,* 349 F. Supp. 1335 (N.D. Ga. 1972), and *New York State Ass'n for Retarded Children,*

Inc. v. Rockefeller, 357 F. Supp. 752 (E.D. N.Y. 1973). *Burnham* was reversed by the Fifth Circuit, 503 F.2d 1319 (5th Cir. 1974), *cert. denied,* 422 U.S. 1057 (1975), and the *Rockefeller court,* in approving a consent decree in that action appeared to be questioning its earlier finding of no constitutional right to treatment:

> Somewhat different legal rubrics have been employed in [the *Donaldson, Wyatt* line of] cases—"protection from harm" in this case and "right to treatment" and "need for care" in others. It appears that there is no bright line separating these standards. In the present posture of this case, there is no need for the court to re-examine the constitutional standard properly applicable to Willowbrook's residents. The relief which the parties agreed to will advance the very rights enunciated in the case law since this court's 1973 ruling.

New York State Ass'n for Retarded Children, Inc. v. Carey, 393 F. Supp. 715, 719 (E.D. N.Y. 1975).

The other courts which have examined the issue have found a constitutional right to treatment or habilitation. *See, e.g., Wyatt v. Aderholt,* 503 F.2d 1305 (5th Cir. 1974); *Donaldson v. O'Connor,* 493 F.2d 507 (5th Cir. 1974), *vacated* 422 U.S. 563 (1975); *Gary W. v. Louisiana,* No. 74-2412 at 14 (E.D. La., filed July 26, 1976), *modified,* October 28, 1976 (involuntarily committed retarded children have a constitutional right "to a program of treatment that affords the individual a reasonable chance to acquire and maintain those life skills that enable him to cope as effectively as his own capacities permit with the demands of his own person and

of his environment and to raise the level of his physical, mental and social efficiency"); *Woe v. Mathews,* 408 F. Supp. 419, 429 (E.D. N.Y. 1976), *remanded in part, dismissed in part sub nom. Woe v. Weinberger,* 556 F.2d 563 (2d Cir. 1977) ("[a]s a tentative formulation it would seem encumbent upon the State as confiner . . . to employ whatever means are necessary, including such care and treatment as are reasonably possible in the circumstance of the case, to promote the speedy release and return to liberty of the person confined."); *Davis v. Watkins,* 384 F. Supp. 1196, 1197 (N.D. Ohio 1974) (the court, dealing with a state facility apparently serving both mentally ill and retarded individuals held that "the State, upon committing an individual 'until he regains his sanity', incurs a responsibility to provide such care as is reasonably calculated to achieve that goal,"); *Saville v. Treadway,* 404 F. Supp. 430 (M.D. Tenn. 1974) (three-judge court), consent agreement approved, 404 F. Supp. 433 (retarded individuals in state institutions have right to habilitative services); *Welsch v. Likins,* 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part and vacated and remanded in part,* 550 F.2d 1122 (8th Cir. 1977) (retarded individuals involuntarily committed to state institutions have a constitutional right to treatment).

The Third Circuit has not yet decided the right to treatment or habilitation question. However, in *Scott v. Plante,* 532 F.2d 939, 947 (1976) it reversed a district court's F. R. Civ. P. 12(b)(6) dismissal of a right to treatment claim by an involuntarily committed mentally ill patient, stating:

> The Supreme Court did not reach the issue in *O'Connor v. Donaldson, supra.* Nor has this court

considered it. It is not the kind of issue, however, which we should attempt to resolve definitively on the record that is before us. . . . It suffices for present purposes to say that it does not appear to a certainty that Scott would be entitled to no relief on his right to treatment claim under any state of facts he could prove in support of that claim. Thus, a Rule 12 (b) (6) dismissal was improper.[53]

We hold that when a state involuntarily commits retarded persons, it must provide them with such habilitation as will afford them a reasonable opportunity to acquire and maintain those life skills necessary to cope as effectively as their capacities permit. *See Gary W. v.*

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[53] The constitutional right to treatment and habilitation has been extended to include other classes of involuntarily committed non-criminal offenders: *See, e.g., McRedmond v. Wilson,* 533 F.2d 757 (2d Cir. 1976) (wayward juveniles who have been institutionalized have a constitutional right to treatment); *Nelson v. Heyne,* 491 F.2d 352, 358 (7th Cir.), *cert. denied,* 417 U.S. 976 (1974) (juveniles who were involuntarily committed—one-third for non-criminal offenses—to a correctional institution have a constitutional right to rehabilitative treatment); *Pena v. New York State Division for Youth,* 419 F. Supp. 203, 207 (S.D. N.Y. 1976) ("this court finds that the detention of a youth under a juvenile justice system *absent provision for the rehabilitative treatment of such youth* is a violation of due process rights guaranteed under the Fourteenth Amendment."); *see also, Morgan v. Sproat,* 432 F. Supp. 1130, 1136 (S.D. Miss. 1977); *Morales v. Turman,* 383 F. Supp. 53, 124 (E.D. Tex. 1974), *rev'd on other grounds,* 535 F.2d 864 (5th Cir. 1976), *judgment of Court of Appeals rev'd and remanded,* U.S. , 97 S.Ct. 1189 (1977); *Inmates of Boys' Training School v. Affleck,* 346 F. Supp. 1334, 1372 (D. R.I. 1972); *Stachulak v. Coughlin,* 364 F. Supp. 686 (N.D. Ill. 1973); and *Martarella v. Kelley,* 349 F. Supp. 575, 600 (S.D. N.Y. 1972).

Louisiana, No. 74-2412 at 14 (E.D. La., filed July 26, 1976), *modified*, October 28, 1976. On the basis of the evidence presented in these proceedings, we find that the retarded residents of Pennhurst have not received, and are not receiving, minimally adequate habilitation. Furthermore, on the basis of this record we find that minimally adequate habilitation cannot be provided in an institution such as Pennhurst. As the Court has heretofore found, Pennhurst does not provide an atmosphere conductive to normalization which is so vital to the retarded if they are to be given the opportunity to acquire, maintain and improve their life skills. Pennhurst provides confinement and isolation, the antithesis of habilitation. We found that Pennhurst has produced regression and in many instances has destroyed life skills possessed by its retarded residents at the time of their admission.[54] We are inclined to agree with the following comments of Mason & Menolascino, *supra* note 6, at 156-7 (footnotes omitted):

> Although *Wyatt* and *Welsch* are significant in their recognition of the principles of normalization and the development model for the factual foundation of their formulation of the constitutional right to habilitation, their approach can be considered only

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[54] There has been no evidence introduced that any of the plaintiffs were committed to Pennhurst because they posed a danger to society, and, thus, we are not faced with that issue in this case. Moreover, as we have heretofore pointed out, the retarded pose no danger of physical harm to society. Retarded individuals who suffer from emotional and mental problems may pose a danger to society; however, these are due to mental and emotional problems which do not come within the purview of this opinion.

the rudimentary beginning. The logic of normalization and the development model which *Wyatt* and *Welsch* recognized suggests full implementation of habilitation can only be achieved in a non-institutional setting. Institutions, by their very structure—a closed and segregated society founded on obsolete custodial models—can rarely normalize and habilitate the mentally retarded citizen to the extent of community programs created and modeled upon the normalization and development approach components of habilitation. Neither *Wyatt* nor *Welsch* fully implemented the right to habilitation in that they failed to challenge the very existence of the institution. Consequently, the two institutional characteristics most antithetical to the application of the normalization principle remain intact: segregation from the community and the total sheltering of retarded citizens in all spheres of their lives.

We wish to make it clear that our finding that the retarded at Pennhurst are being deprived of their constitutional right to minimally adequate habilitation is not limited to those residents who were court committed. Nearly fifty percent of the residents at Pennhurst did not go through court commitment procedures. They have been, and are being, deprived of minimally adequate habilitation to the same extent as those who were court committed. Moreover, as we have heretofore found, voluntariness in connection with admission and exit from Pennhurst is an illusory concept. The record in this case shows that Pennhurst residents had no practical alternative at the time of their admission and at the present time, they have no place else to go.

No constitutional mandate has been called to our attention which would require a state to provide habilitation for its retarded citizens. However, whenever a state accepts retarded individuals into its facilities, it cannot create or maintain those facilities in a manner which deprives those individuals of the basic necessities of life. In the case of the retarded, this constitutes an obligation to provide them with minimally adequate habilitation. *See Welsch v. Likins,* 550 F.2d 1122, 1132 (8th Cir. 1977); *Nelson v. Heyne,* 491 F.2d 352, 360 (7th Cir.), *cert. denied,* 417 U.S. 976 (1974); *Vanderzeil v. Hudspeth,* No. J76-262(R) at 6 (S.D. Miss., filed February 11, 1977).

Once admitted to a state facility, the residents have a constitutional right to be provided with minimally adequate habilitation under the least restrictive conditions consistent with the purpose of the commitment. *Eubanks v. Clarke,* No. 76-2491 at 8 (E.D. Pa., filed July 1, 1977); *J. L. v. Parham,* 412 F. Supp. 112, 139 (M.D. Ga. 1976) (three-judge court), *appeal pending* U.S. , 97 S. Ct. 2647 (1977); *Gary W. v. Louisiana,* No. 74-2412 (E.D. La., filed July 26, 1976), *modified,* October 28, 1976; *Woe v. Mathews,* 408 F. Supp. 419, 428 (E.D. N.Y. 1976), *remanded in part, dismissed in part sub nom. Woe v. Weinberger,* 556 F.2d 563 (2d Cir. 1977); *Suzuki v. Quisenberry,* 411 F. Supp. 1113, 1132-33 (D. Hawaii 1976); *Lynch v. Baxley,* 386 F. Supp. 378, 392 (M.D. Ala. 1974); *Davis v. Watkins,* 383 F. Supp. 1196, 1206 (N.D. Ohio 1974); *Saville v. Treadway,* 404 F. Supp. 430, 437 (M.D. Tenn. 1974); *Welsch v. Likens,* 373 F. Supp. 487, 502 (D. Minn. 1974), *aff'd in part and vacated and remanded in part,* 550 F.2d 1122 (8th Cir.

1977); *Morales v. Turman,* 383 F. Supp. 53, 124 (E.D. Tex. 1974), *rev'd on other grounds,* 535 F.2d 864 (5th Cir. 1976), *judgment of Court of Appeals rev'd and remanded,* U.S. , 97 S.Ct. 1189 (1977); *Wyatt v. Stickney,* 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part, remanded in part and decision reserved in part sub nom. Wyatt v. Aderholt,* 503 F.2d 1305 (5th Cir. 1974); *Lessard v. Schmidt,* 349 F. Supp. 1078, 1096 (E.D. Wisc. 1972) (three-judge court), *vacated and remanded on other grounds,* 414 U.S. 473 (1974); *Dixon v. Attorney General of the Commonwealth of Pennsylvania,* 325 F. Supp. 966, 973-4 (M.D. Pa. 1971) (consent decree), *but see Patton v. Dumpson,* 425 F. Supp. 621, 624 (S.D. N.Y. 1977).[55]

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[55] The *Patton* court was troubled by the fact that in *Sanchez v. New Mexico,* 396 U.S. 216 (1970), the Supreme Court dismissed an appeal from a case which had rejected the least restrictive alternative for "want of a substantial federal question." For the precedential effect of a summary dismissal for want of a substantial federal question *see Mandel v. Bradley,* U.S. , 97 S.Ct. 2238, 2240 (1977) ("Summary actions, however . . . should not be understood as breaking new ground but as applying principles established by prior decisions to the particular facts involved.") Moreover, the constitutional right to treatment and habilitation is a newly developed area of the law. Nearly all of the federal cases dealing with a constitutional right to treatment for mentally ill individuals and a constitutional right to habilitation for retarded individuals have arisen since *Sanchez. See, e.g., O'Connor v. Donaldson,* 422 U.S. 563 (1975); *Wyatt v. Aderholt,* 503 F.2d 1305 (5th Cir. 1974); *Welsch v. Likins,* 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part and vacated and remanded in part,* 550 F.2d 1122 (6th Cir. 1977). We feel that when the Court next examines the issue, it will find that there is such a constitutional right. *See Welsch,* 378 F. Supp. at 501-2; *Lynch,* 386 F. Supp. at 392.

The right to minimally adequate habilitation in the least restrictive alternative stems from the Supreme Court's decision in *Shelton v. Tucker,* 364 U.S. 479 (1960), in which the Court, addressing itself to the question of permissible abridgment of constitutional liberties, stated:

> even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stiffle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.

All admissions to state facilities, be it through court commitment, or otherwise, entail an infringement on fundamental rights and freedoms. *See Eubanks v. Clarke,* No. 76-2491 at 8 (E.D. Pa., filed July 1, 1977). Because of this, due process demands that if a state undertakes the habilitation of a retarded person, it must do so in the least restrictive setting consistent with that individual's habilitative needs. As we have heretofore pointed out, isolation and confinement are counter-productive in the habilitation of the retarded. Furthermore, since the law recognizes that habilitation other than in the least restrictive setting is a violation of one's constitutional rights, there is no question that Pennhurst, as an institution for the retarded, should be regarded as a monumental example of unconstitutionality with respect to the habilita-

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See also, Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190, 1247-8 (1974).

tion of the retarded.[56] The Commonwealth and its subdivisions have a constitutional duty to explore and provide the least stringent practicable alternatives to confinement of retarded individuals at Pennhurst. *Welsch v. Likins,* 373 F. Supp. 487, 502 (D. Minn. 1974), *aff'd in part and vacated and remanded in part,* 550 F.2d 1122 (8th Cir. 1977). On the basis of this record, we find that the Commonwealth and its subdivisions did not fulfill and are not fulfilling its constitutional obligation with respect to the retarded at Pennhurst.

B. *Constitutional Right to be Free from Harm*

The retarded at Pennhurst have been physically abused. Lack of adequate supervision has produced an atmosphere of danger to the residents. Occasionally, there have been incidents of staff abuse of residents, including rape and beatings. Hundreds of injuries, both major and minor, are reported every month.

Residents of state institutions for the retarded have both an Eighth and Fourteenth Amendment right to freedom from harm. *Spence v. Staras,* 507 F.2d 554, 557 (7th Cir. 1974); *Romeo v. Youngberg,* No. 76-3429 at

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[56] Moreover, habilitation in the least restrictive setting answers one of Chief Justice Burger's concerns, expressed in his concurrence in *Donaldson,* with respect to a constitutional right to treatment. His concern is that a state constitutionally might be able to justify indiscriminate confinement of individuals merely by providing treatment. *O'Connor v. Donaldson,* 422 U.S. 563, 589 (1975). Since a state cannot constitutionally confine an individual in other than the least restrictive setting consistent with that individual's habilitative needs, it cannot confine a retarded person in a Pennhurst-like institution if that individual could benefit from habilitation in a less restrictive setting.

3 (E.D. Pa., filed June 6, 1977); *Welsch v. Likin,* 373 F. Supp. 487, 502-3 (D. Minn. 1974), *aff'd in part and vacated and remanded in part,* 550 F.2d 1122 (8th Cir. 1977); *New York State Association for Retarded Children Inc. v. Rockefeller,* 357 F. Supp. 752, 764 (E.D. N.Y. 1973). Defendants have argued that the recent Supreme Court decision, *Ingraham v. Wright,* U.S. , 97 S.Ct. 1401 (1977), limits the applicability of the Eighth Amendment to those convicted of crimes. *Ingraham* held that the use of corporal punishment in public schools did not violate the student's Eighth Amendment rights. *Id.* at 1409. In reaching this result, the Court reasoned:

> The schoolchild has little need for the protection of the Eighth Amendment. Though attendance may not always be voluntary, the public school remains an open institution. Except perhaps when very young, the child is not physically restrained from leaving school during school hours; and at the end of the school day, the child is invariably free to return home. Even while at school, the child brings with him the support of family and friends and is rarely apart from teachers and other pupils who may witness and protest any instances of mistreatment.
>
> The openness of the public school and its supervision by the community afford significant safeguards against the kinds of abuses from which the Eighth Amendment protects the prisoner. In virtually every community where corporal punishment is permitted in the schools, these safeguards are reinforced by

> the legal constraints of the common law. Public school-teachers and administrators are privileged at common law to inflict only such corporal punishment as is reasonably necessary for the proper education and discipline of the child; any punishment going beyond the privilege may result in both civil and criminal liability, . . . As long as the schools are open to public scrutiny, there is no reason to believe that the common law constraints will not affectively remedy and deter excess such as those alleged in this case. *Id.* at 1412 (footnote omitted).

The retarded at Pennhurst have none of these safeguards. Due to their own handicaps, few of the retarded are in a position to aid or protect their fellow residents, or to complain about their own treatment. Pennhurst is isolated and segregated from the community. The residents are not free to leave at the end of the day. In addition, few, if any, of the physically abusive incidents at Pennhurst were committed as disciplinary measures. Furthermore, the *Ingraham* Court specifically reserved the question of the availability of the Eighth Amendment to individuals confined in "mental" institutions. *Id.* at 1411 n.

As stated by Judge Judd in *New York Association for Retarded Children, Inc. v. Rockefeller,* 357 F. Supp. 752, 764-5 (E.D. N.Y. 1973):

> Since Willowbrook [an institution for the retarded] residents are for the most part confined behind locked gates, and are held without the possibility of a meaningful waiver of their right to freedom, they must be entitled to at least the same living

> conditions as prisoners, . . . One of the basic rights of a person in confinement is protection from assaults by fellow inmates or by staff. . . . Another is the correction of conditions which violate "basic standards of human decency."

On the basis of the evidence in this record, we find that the constitutional right to be free from harm of the retarded residents at Pennhurst has been violated.

C. *Constitutional Right to Non-Discriminatory Habilitation*

In a three-judge decision emanating from this court, *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania,* 343 F. Supp. 279 (E.D. Pa. 1972), it was legally recognized for the first time that the retarded had a constitutional right pursuant to the Equal Protection Clause of the Fourteenth Amendment to receive at least as much education and training as was being afforded by the Commonwealth to others.

As stated by Professor Burt in "Beyond the Right to Habilitation", in *The Mentally Retarded Citizen and the Law,* 425-32 (1976):

> The *PARC* theory can and should mean that any state program that segregates mentally retarded citizens as such from others is highly suspect and that courts will require states to treat mentally retarded persons indistinguishably from others, except in ways that are both very limited and very clearly beneficial to the individual. By this test, segregation of the mentally retarded in a remote large-scale institution could never pass constitutional muster . . . .

[E]xisting large-scale geographically remote institutions cannot by their nature provide adequate programs to remedy the intellectual and emotional shortcomings and the galling social stigma that led the retarded residents to these institutions. If this evidence is fully marshaled in litigation, courts can . . . rule that present patterns of state segregation of retarded persons for "habilitation" or "educational" purposes are impermissible. Courts can . . . force states to close the Partlows and Willowbrooks and, even more important, to require alternative programs for mentally retarded persons which treat them as indistinguishably as possible from other persons. . . .

A powerful case can thus be mounted that courts should command states to use extraordinary effort to avoid institutionalizing retarded citizens. By this analysis, *Wyatt* clearly was wrong in failing to address directly the adequacy of community alternatives to geographically remote residential institutional care. In this analysis, the adequacy of in-community residences is not an afterthought. It is central to the inquiry into whether separate treatment for the mentally retarded person is not inherently unequal just as racially segregated education was found inherently unequal in *Brown v. Board of Education.*

In this record, the evidence has been "fully marshaled" and we find that the confinement and isolation of the retarded in the institution called Pennhurst is segregation in a facility that clearly is separate and *not* equal. We are convinced that the same equal protection prin-

ciples enunciated by the court in *Pennsylvania Association of Retarded Children v. Commonwealth of Pennsylvania,* 343 F. Supp. 279 (E.D. Pa. 1972), prohibit the segregation of the retarded in an isolated institution such as Pennhurst where habilitation does not measure up to minimally adequate standards. As we have heretofore discussed in this opinion, the retarded at Pennhurst have been segregated in an institution in which they have been and are being denied minimally adequate habilitation. Thus, on the basis of this record we find that the retarded at Pennhurst have been and presently are being denied their Equal Protection Rights as guaranteed by the Fourteenth Amendment to the Constitution.

D. *Pennsylvania Statutory Right to Minimally Adequate Habilitation.*

The question has also been presented to the Court as to whether the residents at Pennhurst have a statutory right to minimally adequate habilitation. 50 P.S. §4201 provides in pertinent part:

> The department [of public welfare] shall have power, and its duty shall be:
>
> (1) To assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them . . . .

This statute was first interpreted in *In Re: Joyce Z., a minor child,* No. 2035-69 (Common Pleas, Allegheny County, filed March 31, 1975). Joyce Z.'s caseworker petitioned the court, pursuant to 50 P.S. §4406.[57] to commit Joyce to a state facility for care and treatment.

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[57] *See supra* note 12.

The caseworker suggested Western State School and Hospital as a proper facility for Joyce's commitment. A commitment hearing was held at which all the witnesses, including the superintendent of the institution itself, testified that Joyce would not receive adequate treatment at Western State School and Hospital. *Id.* at 9. In fact, the Commissioner of Mental Retardation for the Department of Welfare, Western Region, testified that if Joyce were placed in the institution, the regression which she was presently experiencing would continue because she would not be able to interact with staff due to staff shortages. *Id.* at 4. In its opinion the court, in construing 50 P.S. §4201, stated:

> These are brave words. We mean to see that the State, acting through the Department of Public Welfare, abides by them.
>
> Joyce has a right to life given to her by the Constitution of the United States; *she has a right to treatment given to her by the Mental Health and Mental Retardation Act of Pennsylvania;* this court may order that course of treatment best suited to meet Joyce's needs.

Id. at 10-11. (Emphasis supplied).

It is abundantly clear that the Mental Health and Mental Retardation Act, 50 P.S. §§4201 *et seq.*, grants to the retarded in Pennsylvania the statutory right to minimally adequate habilitation. *See Eubanks v. Clarke,* No. 76-2491 at 6 (E.D. Pa., filed July 1, 1977); *In Re Joyce Z.*[58] Furthermore, it is equally clear that the Com-

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[58] *Cf. Janet D. v. Carros,* 240 Pa. Superior Ct. 291, 362 A.2d 1060 (1976) (Juvenile Court Act, 11 P.S. §§50-101 *et seq.*, provides civilly committed juveniles a right to treatment).

monwealth and the counties have been charged under the Act with the responsibility of providing such minimally adequate habilitation to the retarded. The Act envisions

> a comprehensive cooperative State-county (or multi-county) program for the care, treatment and rehabilitation of persons who are . . . mentally retarded . . . . The State, through the Department of Welfare, is responsible for the overall supervision and control of the program to assure the availability of and equitable provision for adequate . . . mental retardation facilities, and the counties, separately or in concept, are assigned responsibilities as to particular programs. *Hoolick v. Retreat State Hospital,* 24 Pa. Cmwlth. 218, 221-22, 354 A.2d 609, 611 (1976). *See also,* 50 P.S. §4201 (8).[59]

On the basis of this record, we find that both the Commonwealth and the counties have violated their statutory obligation to provide minimally adequate habilitation to the retarded residents at Pennhurst. In particular, the Commonwealth has violated the statutory mandate to supervise and control the program of minimally adequate habilitation to these individuals.

E. *Federal Statutory Right to Non-Discriminatory Habilitation*

The question has also been presented whether Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794, grants federal statutory rights to the retarded resi-

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[59] The counties also have the power to establish "[a]ny other service or program designed to prevent . . . the necessity of admitting or committing the mentally disabled to a facility." 50 P.S. §4301(e)(3).

dents at Pennhurst which have been violated. Section 504 provides:

> No otherwise qualified handicapped individual in the United States, as defined in section 706(6) of this title, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

There is no question that the retarded are "handicapped individuals" within the meaning of the act; 42 Fed. Reg. 22678; *cf. Rhode Island Society for Autistic Children v. Board of Regents for Education for the State of Rhode Island,* No. 5081 at 8 (D. R.I., filed August 1, 1975), nor is there any question that Pennhurst is a "program or activity receiving Federal financial assistance."

In enacting Section 504 of the Rehabilitation Act of 1973, Congress has in effect codified the constitutional right to equal protection. Section 504 was originally introduced in 1971-72 as a bill to include the handicapped in the Civil Rights Act of 1964. Introducing the bill in the Senate on January 20, 1972, Senator Humphrey, its primary sponsor there, said:

> I introduce . . . a bill . . . to insure equal opportunities for the handicapped by prohibiting needless discrimination in programs receiving Federal financial assistance . . . . The time has come when we can no longer tolerate the invisibility of the handicapped in America. . . . I am calling for public attention to three-fourths of the Nation's institutionalized mentally retarded, who live in public and pri-

> vate residential facilities which are more than 50 years old, functionally inadequate, and designed simply to isolate these persons from society. . . . These people have the right to live, to work to the best of their ability—to know the dignity to which every human being is entitled. But too often we keep children, whom we regard as "different" or a "disturbing influence" out of our schools and community activities altogether . . . . Where is the cost-effectiveness in consigning them to . . . "terminal" care in an institution?
>
> These are people who can and must be helped to help themselves. That this is their constitutional right is clearly affirmed in a number of recent decisions in various judicial jurisdictions. 118 Cong. Rec. 525 (1972).

In view of our finding that the Equal Protection Clause of the Fourteenth Amendment prohibits the segregation of the retarded in an isolated institution such as Pennhurst where the habilitation provided the retarded does not meet minimally adequate standards, consistency requires that we find that the Pennhurst residents' federal statutory right to habilitation in a non-discriminatory manner has been violated. *See Nettie T. v. Charles E. Holladay,* No. DC 75-31-S (N.D. Miss., filed July 20, 1977). We hold that Section 504 confers a private right of action; that it imposes affirmative obligations on state and local governmental officials and that under Section 504 unnecessarily separate and minimally inadequate services are discriminatory and unlawful. *Lloyd v. Regional Transportation Authority,* 548 F.2d 1277 (7th Cir.

1977); *Barnes v. Converse College,* No. 77-1116 (D. S.C., filed July 12, 1977); *Gurmankin v. Castanzo,* 411 F. Supp. 982 (E.D. Pa. 1976) *aff'd,* 556 F.2d 184 (3d Cir. 1977); 42 Fed. Reg. 22687 (1977); *cf. Lau v. Nichols,* 414 U.S. 563 (1974). On the basis of this record, we find that the rights of the retarded at Pennhurst under Section 504 of the Rehabilitation Act of 1973 have been and are being violated.

V. *Liability of the Individual Defendants*

Plaintiffs Terri Lee Halderman, Larry Taylor, Kenny Taylor, Robert Sobetsky, Theresa Sobetsky, Nancy Beth Bowman, George Sorotos, and Linda Taub[60] are retarded individuals who resided at Pennhurst. They seek monetary damages for injuries received while at the institution from the following defendants: Frank S. Beal (Secretary of the Pennsylvania Department of Public Welfare); Stanley Meyers (Deputy Secretary for Mental Retardation, Pennsylvania Department of Public Welfare); Helen Wohlgemuth (former Secretary of the Pennsylvania Department of Public Welfare); Aldo Colautti (Executive Deputy Secretary, Pennsylvania Department of Public Welfare); Wilbur Hobbs (Deputy Secretary for Southeastern Region, Pennsylvania Department of Public Welfare); Russell Rice, Jr. (Commissioner of Mental Retardation for Southeastern Region, Pennsylvania Department of Public Welfare); C. Duane Youngberg (Superintendent of Pennhurst); Robert Smilovitz (former Assistant Superintendent of Pennsylvania); Joseph Foster

[60] Mr. Taub testified that neither he nor his daughter, Linda seek monetary damages despite the allegation in the complaint to the contrary.

(Assistant Superintendent of Pennhurst); Margaret Green (employee at Pennhurst); Betty Uphold (a supervisor on Unit 9 at Pennhurst); Alice Barton (a supervisor on Unit 7 at Pennhurst); P. E. (Pauline) Klick (charge aid on suffer serious injury during their residence at Pennhurst. physician) and Helen Francis (Director of Nursing at Pennhurst).

As the Court heretofore found, these plaintiffs did suffer serious injury during their residents at Pennhurst. However, there was no evidence introduced at trial that any one of the above named defendants was, in any way, personally involved with the physical abuses inflicted upon these residents. To the contrary, the evidence shows that the defendants acted in the utmost good faith and that they did not know nor reasonably should have known that the action which they took, or failed to take, within the sphere of their official responsibilities were in any way violative of the rights of the retarded residents at Pennhurst. For the most part, the evidence showed that those affiliated with the administration of Pennhurst were dedicated and sincere in their efforts to habilitate the retarded who came within the sphere of their supervision. They apparently took every means available to them to reduce the incidents of abuse and injury, but were constantly faced with staff shortages. In addition, as we have already found, the administration at Pennhurst was saddled with an institution which by its very nature produced an atmosphere conducive to injury. The Court, therefore, finds that the defendants have met their burden of convincting us by a preponderance of the evidence that they are entitled to the good faith immunity from damages afforded to such officials in connection with the injuries

suffered by the name plaintiffs. *O'Connor v. Donaldson,* 422 U.S. 563, 576-77 (1975); *Wood v. Strickland,* 420 U.S. 308 (1975); *Thompson v. Burke,* 556 F.2d 231, 239-40 (3d Cir. 1977); *Skehan v. Board of Trustees of Bloomsburg State College,* 538 F.2d 53, 59-62 (3d Cir. 1976). We find that the individual defendants are dedicated professionals in the field of retardation who were given very little with which to accomplish the habilitation of the retarded at Pennhurst.

Accordingly, we find that there is no basis for awarding monetary damages in this case.

VI. *Conclusion*

This opinion is in lieu of Findings of Fact and Conclusions of Law, pursuant to Rule 52(e) of the Federal Rules of Civil Procedure. As we have attempted to make clear, our Findings and Conclusions pertain solely to the retarded at Pennhurst.

For the reasons heretofore enunciated, the Court finds that the retarded at Pennhurst have been and are presently being denied certain constitutional and statutory rights in connection with their institutionalization at Pennhurst.

In an Order filed this date, we have scheduled a hearing for Friday, January 6, 1978 at 9:00 a.m. in Courtroom 10-B of this United States Courthouse, 601 Market Street, Philadelphia, Pennsylvania for the purpose of determining the appropriate relief to be granted.

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

Civil Action No. 74-1345

Terri Lee Halderman, et al.,
Plaintiffs

Pennsylvania Association for Retarded Citizens, et al.,
Plaintiff-Intervenors

United States of America,
Plaintiff-Intervenor

v.

Pennhurst State School and Hospital, et al.,
Defendants

MEMORANDUM

BRODERICK, *J.*, March 17, 1978.

In an opinion filed on December 23, 1977, this Court made findings of fact and conclusions of law in this matter. Upon its findings, the Court held that the constitutional and statutory rights of the retarded at Pennhurst State School and Hospital ("Pennhurst") had been and are being violated. Some of the determinations made by the Court in its opinion were:

1. That when a state institutionalizes individuals because they are retarded, the United States Constitution

(Eighth and Fourteenth Amendments) and the laws of Pennsylvania (50 P.S. §§4101 *et seq.*) require the state to provide such minimally adequate habilitation as will afford a reasonable opportunity for them to acquire and maintain such life skills as are necessary to enable them to cope as effectively as their capacities permit.

2. That the Rehabilitation Act of 1973, 29 U.S.C. §794, grants rights to the retarded residents of Pennhurst, which rights have been and are being violated.

3. That the retarded at Pennhurst are not receiving minimally adequate habilitation and that such minimally adequate habilitation cannot be provided at Pennhurst because it does not provide an atmosphere conducive to normalization, which the experts all agree is vital to the minimally adequate habilitation of the retarded.

Having concluded the liability phase of this litigation, we must now determine the appropriate relief. In view of the Court's finding that institutionalization at Pennhurst is not conducive to normalization, which is vital to the habilitation of the retarded, our Order must provide that immediate steps be taken to remove the retarded residents from Pennhurst. Great caution and care must be exercised, however, to make certain that each and every retarded resident who is moved from Pennhurst can be accommodated in a community facility which will provide minimally adequate habilitation. Furthermore, the Court's Order shall not be construed to limit in any manner the use of the Pennhurst facilities from any other purpose in the future.

A hearing was held on January 6, 1978, at which the Court requested that the parties meet and attempt to

agree upon a Court Order which would be acceptable to all the litigants. After meeting, the parties informed the Court that they had been unable to agree and would never be able to agree. The Court then directed that the parties submit proposed Orders detailing their views as to the appropriate relief for the Court to grant together with a memorandum pointing out what they considered unacceptable in their opponent's proposed Order.

The Order submitted by the Commonwealth defendants contained a plan which was essentially the same plan introduced by them at the trial in May, 1977. As was pointed out in this Court's opinion, the Commonwealth defendants agreed that the retarded should be removed from Pennhurst and readily admitted that the only reason that the litigation was necessary was because they wished to accomplish the closing of Pennhurst as a residence for the retarded, pursuant to their own schedule which was vague and indefinite.

A final hearing was held on January 16, 1978, at which time the parties informed the Court that they did not intend to introduce any additional evidence. All the parties agreed that the record in this case contained all the evidence necessary for the Court to formulate its Order.

Accordingly, we shall this date enter an Order of judgment in favor of the plaintiffs and against the defendants, and shall mandate the appropriate injunctive relief necessary to remedy the constitutional and statutory violations which the Court in its Opinion of December 23, 1977 found are being suffered by the retarded residents at Pennhurst.

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ORDER

AND NOW, this 17th day of March, 1978, pursuant to findings of fact and conclusions of law made by the Court in an Opinion filed December 23, 1977, it is hereby ORDERED that judgment is entered in favor of the plaintiffs and against the defendants, and injunctive relief is ORDERED as follows:

1. Commonwealth and county defendants, their successors, and their officers, agents, servants, employees, attorneys and all persons in active concert or participation with them are permanently enjoined to provide suitable community living arrangements for the retarded residents

of Pennhurst, and those retarded persons on its waiting list, together with such community services as are necessary to provide them with minimally adequate habilitation until such time as the retarded individual is no longer in need of such living arrangement and/or community service.

2. Commonwealth and county defendants, as aforesaid, are permanently enjoined to develop and to provide a written individualized program plan, formulated in accordance with professional standards (Opinion, page 25; Roos N.T. 1-115, 1-116, Hare N.T. 8-168) to each member of plaintiff class, to provide to each an individualized habilitation program, to provide annual periodic review thereof and the opportunity to each member of plaintiff class and to his or her next friend to be heard thereon.

3. Commonwealth and county defendants, as aforesaid, are permanently enjoined to provide all necessary and proper monitoring mechanisms to assure that community living arrangements and other community services of the necessary quantity and quality are provided and maintained.

4. Commonwealth and county defendants, as aforesaid, are permanently enjoined to implement with dispatch Act 256 of the 1970 Pennsylvania General Assembly, the specific schedule to be set by further Order of this Court upon recommendation of the Master as set forth in paragraph 6 (a) below.

5. The Court, on the basis of nine weeks' testimony in this case and the submissions of all parties, finds that the implementation of this Order will be impossible with-

out the appointment of a Special Master, and, therefore, pursuant to Rule 53, Fed. R. Civ. P. and in the exercise of the Court's equitable powers, the Court shall appoint a Special Master with the power and duty to plan, organize, direct, supervise and monitor the implementation of this and any further Orders of the Court. Commonwealth and county defendants, their successors, officers, agents, servants, employees, attorneys and all persons in active concert or participation with them shall provide the Master with access to all premises, records, documents and personnel and residents and with every other cooperation and service necessary to the discharge of the Master's duties and shall make available to the Master all professional and other resources of the Department of Public Welfare, the Pennhurst State School and Hospital, the County Offices of Mental Retardation and the Base Service Units as may be necessary to execute this Court's Orders.

6. This Special Master shall prepare and present to this Court for its approval and Order a Plan of Implementation which shall include the following:

(a) A plan specifying the quantity and type of community living arrangements and other community services necessary for the habilitation of all plaintiffs in the least separate, most integrated, least restrictive community setting, taking into account the existing community services in the five county area and including, by county, specification of the residential, program and staffing patterns necessary, the delineation of responsibility for their creation and maintenance, their funding and a specified time frame for their provision.

(b) A report specifying resources, procedures, and a schedule for individual evaluations and the formulation of individual exit and community program plans required for the habilitation of each member of plaintiff class and for their periodic review.

(c) A plan for the recruitment, hiring and training of a sufficient number of qualified community staff to be detailed to each Base Service Unit to manage the preparation of individual exit and community program plans for each member of plaintiff class and upon completion of such plans to assist in the execution of the responsibility to create, develop, maintain, and monitor the community living arrangements and other services required.

(d) A plan for the creation, development and maintenance of mechanisms to monitor a system of community services to assure that community living arrangements and other community services of the necessary quality and quantity are continuously provided to retarded persons in the least separate, most integrated, least restrictive community setting, which plan shall include but shall not be limited to the provision of friend-advocates to assist in the protection of the rights of each member of plaintiff class.

(e) A plan to provide retarded people, members of the class, with continuing information concerning the effect and the implementation of the Court's decision, concerning the plans to provide all necessary community living arrangements and other community services to their relative and any other general or specific information regarding the condi-

tions necessary to habilitation of retarded persons and to provide for consultation with them.

(f) A plan to provide parents and family of the members of the class with continuing information concerning the effect and the implementation of the Court's decision, concerning the plans to provide all necessary community living arrangements and other community services to their relative and any other general or specific information regarding the conditions necessary to habilitation of retarded persons and to provide for consultation with them.

(g) A plan to provide opportunities for alternative employment to each employee of Pennhurst State School and Hospital, including employment in community programs and otherwise.

7. Within not more than sixty (60) days after appointment, the Master shall file with this Court the reports required at paragraphs 6(a) and (b) above and 11 below. A hearing will then be scheduled by the Court within fifteen (15) days from the date of their filing. Following the adoption of any plan by Order of the Court, it shall be implemented forthwith.

8. The Master shall engage such staff of his or her own as he or she finds necessary, subject to the approval of the Court. The Master and his or her staff shall be compensated by commonwealth defendants at a rate to be set by the Court; the expenses of the mastership shall be borne by the commonwealth defendants. The Master shall promptly submit to the Court a form of Order with respect to these matters.

9. County defendants, as aforesaid, are hereby enjoined from recommending or in any way counselling that

any individual be committed to Pennhurst, and from petitioning for the commitment of any individual to Pennhurst, and from advancing in any way any application for admission to Pennhurst, and are herewith enjoined from participating in any program or activity in connection with the placement in the future or commitment in the future of any retarded person at Pennhurst.

10. Commonwealth defendants, as aforesaid, are hereby enjoined from recommending or in any way counselling that any individual be committed to Pennhurst, and from petitioning for the commitment of any individual to Pennhurst, and from advancing in any way any application for admission to Pennhurst, and are herewith enjoined from participating in any program or activity in connection with the placement in the future or commitment in the future of any retarded person at Pennhurst. Commonwealth defendants are further enjoined from providing a residence and/or habilitation to any retarded person who is not as of this date a resident at Pennhurst.

11. The Special Master, as aforesaid, shall prepare and present to the Court for its Order a plan for the interim operation of Pennhurst pending its prompt replacement by community living arrangements and other community services. The plan shall address, but need not be limited to, the matters referenced in paragraphs 12-19 below, any other condition at Pennhurst which threatens the life, safety or well-being of any Pennhurst resident, and measures to assure that the interim operation of Pennhurst, including all activities therein, contributes to the prompt provision of services in the community necessary to the habilitation of each Pennhurst resident.

12. Commonwealth defendants are hereby mandated to take every precaution to prevent the physical or psychological abuse, neglect or mistreatment of any Pennhurst resident. Each and every alleged incident of abuse, neglect or mistreatment shall be promptly investigated. The manner and mechanisms of such investigations shall be developed and established by the plan referenced in paragraph 11.

13. Commonwealth defendants are hereby enjoined to exert the maximum effort in enforcing the following Department of Public Welfare regulations on the "Use of Restraints in Treating Patients/Residents" and "Personnel Rules and Institutional Policy on Acts of Abuse Against Patients/Residents" (promulgated in 7 Pennsylvania Bulletin 3199 (October 29, 1977)) which include *inter alia* the following requirements:

a. That mechanical restraints controlling involuntary movement or lack of muscular control due to organic conditions be employed only as part of an individual program plan, upon a finding of the program team trained in the use of such restraints, and only when necessary to 1) prevent injury to self or others, or 2) promote normative body positioning and physical functioning.

b. That restraints shall be used to control acute or episodic, aggressive behavior only when a resident is acting in such a manner as to be a clear and present danger to self or others and only when less restrictive measures and techniques have been proven to be less effective.

c. That mechanical restraints may be used only upon the order of a qualified mental retardation

professional for a period not to exceed two hours; that the resident must be checked every fifteen minutes and must be examined by a physician before the initial order is renewed.

d. That chemical restraints may be administered only upon the order of a physician.

e. That seclusion (practice of placing a resident alone in a locked room) is prohibited in all cases except where it is apparent that there exists a clear and present danger to the resident, other residents or staff and all other less restrictive methods have failed or have been deemed inappropriate. (Title XIX—ICF-MR 249.13 and State Agency Letter No. 77-30 issued December 14, 1977.)

f. That individual program plans shall require and document that all possible attempts be made at preventing assaultive behavior by positive, constructive intervention.

g. That acts of abuse by employees directed at residents are absolutely prohibited and are cause for disciplinary action including dismissal.

h. That an abusive act is any action which may cause or causes physical or emotional harm or injury and includes any willful action which violates the regulations on use of restraints.

14. Commonwealth defendants are hereby enjoined from:

(a) Administering excessive or unnecessary medications to class members;

(b) Using medication as punishment, for the convenience of the staff, as a substitute for program-

ming, or in quantities that interfere with a Pennhurst resident's functioning;

(c) Failing to ensure that only appropriately trained staff are allowed to administer drugs to residents;

(d) Failing to provide training programs to staff who administer drugs to residents. The nature of such training programs, and the qualifications to be required of staff members who administer drugs to residents shall be established in the plan;

(e) Administering drugs to residents on a p.r.n. basis. Written policies and procedures governing the safe administration and handling of medications shall be established pursuant to guidelines developed in the plan;

(f) Failing to monitor and to provide for at least monthly reviews by a physician of each resident's medications.

15. Commonwealth defendants are enjoined from failing to provide a program of medical and health related services for residents which provides accessibility, quality and continuity of care for physical illness or injury. The plan of implementation shall develop and establish detailed standards for the provision of adequate medical and health related services to residents.

16. Commonwealth defendants are hereby enjoined from failing to provide individualized adaptive wheelchairs to each physically handicapped resident who needs them. Each and every individual resident shall be immediately evaluated to ascertain the need for such equipment.

17. Commonwealth defendants are hereby enjoined from feeding any resident in the supine position or in any position less than the maximum upright position consistent with their capabilities and handicaps.

18. Commonwealth defendants are hereby enjoined from denying any resident programmed activities as punishment.

19. Commonwealth defendants are enjoined to take every precaution to keep every Pennhurst building currently housing residents clean, odorless and insect-free at all times.

20. All bulletins, memoranda, directives of official policy issued by the defendants in connection with the implementation of this Court's Order, shall, upon issuance, be sent to counsel for each of the plaintiffs.

21. Jurisdiction is retained by this Court until further Order.

(s) Raymond J. Broderick
Raymond J. Broderick, *J.*

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

Nos. 78-1490, 78-1564 and 78-1602

Terri Lee Halderman, a retarded citizen, by her mother and guardian, Winifred Halderman; Larry Taylor, a retarded citizen, by his parents and guardians, Elmer and Doris Taylor; Kenny Taylor, a minor, a retarded citizen, by his parents and guardians, Elmer and Doris Taylor; Robert Sobetsky, a minor, a retarded citizen, by his parents and guardians, Frank and Angela Sobetsky; Theresa Sobetsky, a retarded citizen, by her parents and guardians, Frank and Angela Sobetsky; Nancy Beth Bowman, a retarded citizen, by her parents and guardians, Mr. and Ms. Horace Bowman; Linda Taub, a retarded citizen, by her parents and guardians, Mr. and Mrs. Allen Taub; George Sorotos, a minor, a retarded citizen by his foster parents, William and Marion Caranfa, all of the above individually and on behalf of all others similary situated; The Parents and Family Association of Pennhurst

Pennsylvania Association for Retarded Citizens, Jo Suzanne Moskowitz, a minor, by her parents and next friends, Leonard and Nancy Moskowitz, Robert Hight, a minor, by his parents and next friends, John and Jeanne Hight, David Preusch, a minor by his parents and next friends, Calvin and Elizabeth Preusch, and Charles DiNolfi, On behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors

United States of America,
Plaintiff-Intervenor

vs.

Pennhurst State School & Hospital, Department of Public Welfare of the Commonwealth of Pennsylvania, Frank S. Beal, Secretary of the Department of Public Welfare, Stanley Meyers, Deputy Secretary for Mental Retardation, Department of Public Welfare, Helene Wohlgemuth, Former Secretary, Department of Public Welfare, Aldo Colautti, Executive Deputy Secretary, Department of Public Welfare, Wilbur Hobbs, Deputy Secretary for Southeastern Region, Department of Public Welfare, Russell Rice, Jr., Commissioner of Mental Retardation for Southeastern Region, Department of Public Welfare, C. Duane Youngberg, Superintendent, Pennhurst State School & Hospital, Robert Smilovitz, Former Assistant Superintendent, Pennhurst State School & Hospital, Joseph Foster, Assistant Superintendent, Pennhurst State School & Hospital, Margaret Green, Betty Uphold, Alice Barton, P. E. Klick, Dr. Parocca, Helen Francis, employees and agent of Pennhurst State School & Hospital, John Doctor, James Nurse, Jane Aide, Jill Therapist, Richard Roe, Jane Doe, unknown and unnamed staff, employees and agents of Pennhurst State School & Hospital, each individual Defendant sued individually and in his or her official capacity, George Metzger, Joseph Catania, and Roger Bowers, Commissioners for Bucks County, Robert Strebl, Earl Baker, and Leo McDermott, Commissioners for Chester County, Faith R. Whittlesey, Charles Keeler and William Spingler, Commissioners for Delaware County, A. Russell Parkhouse, Frank W. Jenkins and Lawrence H. Curry, Commissioners for Montgomery County, Mayor Frank L. Rizzo and The City

Counsel of Philadelphia, as Authorities for Philadelphia County, Peter Bodenheimber, Mental Health/Mental Retardation Administrator for Bucks County, William A. McKendry, Mental Health/Mental Retardation Administrator for Chester County, P. Paul Burrichter, Mental Health/Mental Retardation Administrator for Delaware County, Hermann A. Roether, Mental Health/Mental Retardation Administrator for Montgomery County, and Leon Soffer, Mental Health/Mental Retardation Administrator for Philadelphia County, Commonwealth of Pennsylvania Defendants Pennhurst State School & Hospital, Department of Public Welfare of the Commonwealth of Pennsylvania, Frank S. Beal, Stanley Meyers, Helene Wohlgemuth, Aldo Colautti, Wilbur Hobbs, Russell Rice, Jr., C. Duane Youngberg, Robert Smilovitz, Joseph Foster, Margaret Green, Betty Uphold, Alice Barton, P. E. Klick, Dr. Parocca, and Helen Francis,

Appellants in No. 78-1490

George Metzger, Joseph Catania, and Roger Bowers, Commissioners for Bucks County, and Peter Bodenheimber, Mental Health/Mental Retardation Administrator for Bucks County, Robert G. Strebl, Earl M. Baker, and Leo McDermott, Commissioners for Chester County, and William A. McKendry, Mental Health/Mental Retardation Administrator for Chester County, Faith Ryan Whittlesey, Charles C. Keller, and William A Spingler, Commissioners for Delaware County, and P. Paul Burrichter, Mental Health/Mental Retardation Administrator for Delaware County and A. Russell Parkhouse, Frank W. Jenkins, and Lawrence H. Curry, Commissioners for Montgomery County, and Hermann A. Roether, Mental Health/Mental Retardation Administrator for Montgomery County,

Appellants in No. 78-1564

Mayor Frank L. Rizzo, The City Counsel of
Philadelphia, and Leon Soffer,
Appellants in No. 78-1602

On Appeal From the United States District Court for the Eastern District of Pennsylvania
(D.C. Civil No. 74-1345)

Argued: January 9, 1979

Before: Seitz, *Chief Judge,* Gibbons and Higginbotham, *Circuit Judges*

Reargued en banc September 6, 1979

Before: Seitz, *Chief Judge,* Aldisert, Gibbons, Rosenn, Hunter, Weis, Garth, Higginbotham and Sloviter, *Circuit Judges*

(Opinion Filed December 13, 1979)

Norman J. Watkins (Argued), Deputy Attorney General, Chief, Civil Litigation.

David Ferleger, Esq. (Argued), 37 S. 20th Street, Suite 601, Philadelphia, Pa. 19103, Attorney for Appellees, Terri Lee Halderman, et al.

Robert B. Hoffman, Deputy Attorney General; Gerald Gornish, Acting Attorney General, Pa. Department of Justice, Capitol Annex Building, Harrisburg, Pennsylvania 17120, Attorneys for Commonwealth Appellants.

Thomas M. Kittredge, Esquire (Argued), Morgan Lewis & Bockius, 2107 The Fidelity Building, Philadelphia, Pennsylvania 19109, Attorney for the Suburban County Appellants.

Robert N. DeLuca, United States Attorney; Drew S. Days, III (Argued), Ass't Attorney General; Brian K. Landsberg, Frank D. Allen, Jr., Arthur E. Peabody, Jr., Attorneys, Department of Justice, Washington, D.C. 20530, Attorneys for United States.

Jaime Fernandez, Attorney, Office of General Counsel, Department of Health, Education and Welfare, Washington, D.C. (Of Counsel).

Sheldon L. Albert, City Solicitor; Theodore H. Lunine, Deputy City Solicitor; Joseph M. Davidson, Assistant City Solicitor; Marc H. Myers (Argued), Assistant City Solicitor, 801 U.G.I. Building, 1401 Arch Street, Philadelphia, Pa. 19102, Attorneys for Appellants, 78-1602.

Stephens A. Sheller, Esquire (Argued); Bruce M. Ludwig, Esquire, 1515 Locust Street, 7th Floor, Philadelphia, Pennsylvania 19102, Attorneys for the Pennhurst Parents-Staff Association, et al.

Thomas K. Gilhool, Esquire (Argued); Frank J. Laski, Esquire, Edward A. Stutman, Esquire, Public Interest Law Center of Philadelphia, 1315 Walnut Street, Suite 1600, Philadelphia, Pa. 19107, Of counsel: Michael Churchill, Esquire, James J. Raggio, Esquire, Attorneys for Appellees Pennsylvania Association for Retarded Citizens, et al.

James D. Crawford, Esquire (Argued); Schnader, Harrison, Segal & Lewis, 1719 Packard Building, Philadelphia, Pennsylvania 19102, Attorney for Amici Curiae.

Richard Kirschner, Esquire, Robert C. Cohen, Esquire, Markowitz & Kirschner, 1500 Walnut Street, Philadelphia, Pa. 19102, Attorneys for Amicus Curiae.

OPINION OF THE COURT

GIBBONS, *Circuit Judge*, Filed Dec. 13, 1979.

This is an appeal from an order granting class action injunctive relief against the continued maintenance of Pennhurst State School and Hospital (Pennhurst), a facility for the care and training of persons suffering mental retardation. Location in Spring City, Pennsylvania, Pennhurst is operated under the direction of the Pennsylvania Department of Public Welfare. The appellants are Pennhurst, its superintendent and various other officials of the Commonwealth of Pennsylvania responsible for the operation of Pennhurst (the Commonwealth defendants), and five counties in southeastern Pennsylvania from which mentally retarded persons are admitted to Pennhurst (the County defendants).[1] The appellees are the original and intervening plaintiffs, described more fully below. We affirm the trial court's finding of liability, and modify in part the court's decree.

I. PROCEEDINGS BELOW

The action commenced on May 30, 1974, when Terri Lee Halderman, a minor retarded resident of Pennhurst, for herself and all other Pennhurst residents, filed

[1] The Commonwealth defendants are appellants in No. 78-1490. Appellants in No. 78-1564 include Bucks, Chester, Delaware and Montgomery Counties. Philadelphia is appellant in No. 78-1602. In a related case, No. 78-1999, disposed of separately, Pennhurst Parents-Staff Association appeals from the denial of its motion to intervene.

a complaint against the Commonwealth defendants. The complaint alleged that the residents, all of whom are mentally retarded, live in inhumane and dangerous conditions, are subjected to unnecessary physical restraints, are given unnecessary and dangerous medication, are consigned to lives of idleness because of lack of habilitative programs, and are subjective to numerous physical injuries resulting from a lack of adequate supervision. The complaint further charged that the regimen of Pennhurst caused Halderman and her class to deteriorate and regress emotionally, intellectually and physically. The conditions to which residents were subjected, she claimed, denied the class members due process and equal protection of the law, and inflicted on them cruel and unusual punishment. Halderman sought both injunctive relief against the conditions at Pennhurst and money damages for past injuries.

In November 1974, the United States moved pursuant to Rule 24, Fed. R. Civ. P. 24, to intervene as a plaintiff. Its complaint sought injunctive relief against the Commonwealth defendants, citing the same conditions about which Halderman had complained. The Commonwealth defendants opposed intervention by the United States, but it was granted on January 17, 1975.[2]

On June 3, 1975, the Pennsylvania Association for Retarded Citizens (PARC) and several additional mentally retarded residents of Pennhurst moved to intervene. Like the United States, PARC and the additional indi-

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[2] The Commonwealth defendants thereafter sought a writ of mandamus from this court to compel the district court to dismiss the United States as a party. The writ was denied, and petitions for certiorari and for a stay of this court's order were denied by the Supreme Court. *Beal v. Broderick*, 431 U.S. 933 (1977).

vidual plaintiffs sought only injunctive relief and proceeded only against the Commonwealth defendants.

Thereafter PARC and Halderman amended their complaints to seek relief, not only against the Commonwealth defendants, but also against the County defendants, who it was alleged, were responsible for the commitment of the mentally retarded to Pennhurst and also for the lack of local community facilities, access to which the class members were entitled. In the amended complaint the PARC and Halderman plaintiffs alleged violations of various rights arising under the eighth and fourteenth amendments of the United States Constitution; under section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794 (1976); under the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§6001-6081 (1976); under the Pennsylvania Mental Health and Mental Retardation Act of 1966, Pa. Stat. Ann. tit. 50 §§4101-4704 (Purdon 1969). The district court, on November 29, 1976, denied motions to dismiss filed by the various defendants, and entered an order determining that the action should be maintained as a class action, the class consisting of "all persons who as of May 30, 1974, and at any time subsequent, have been or may become residents of Pennhurst . . ." This included, besides current residents of the institution, all mentally retarded residents of the five counties of southeastern Pennsylvania who might in the future be placed in Pennhurst.

After extensive pretrial discovery, trial of the action commenced on April 18, 1977, and continued until June 13, 1977. On December 23, 1977, the trial judge made findings of fact and conclusions of law holding that the defendants were violating the rights of members of the

mentally retarded class secured to them by section 504 of the Rehabilitation Act of 1973, by the Pennsylvania Mental Health and Mental Retardation Act of 1966, Pa. Stat. Ann. tit. 50, §§4201-4704 (Purdon 1969), by the due process and equal protection clauses of the fourteenth amendment, and by the eighth amendment prohibition against cruel and unusual punishment.[3] The court held that the mentally retarded have a federal statutory right to nondiscriminatory habilitation, a Pennsylvania statutory right to minimally adequate habilitation, and federal constitutional rights to nondiscriminatory habilitation, freedom from harm, and adequate treatment by the least restrictive means. Each of these rights was found to have been violated by the conditions of confinement at Pennhurst. Thereafter, on January 6, 1978, the court held a separate hearing on relief. The court requested that the parties meet and attempt to agree upon an order satisfactory to all the litigants. After meeting, the parties informed the court that they could not, and would not be able to, agree on an order. The court then asked the parties to submit separate proposed orders.

On March 17, 1978, the court issued the order from which these appeals were taken.[4] The court ordered that Pennhurst eventually be closed and suitable community living arrangements and necessary support services provided for all Pennhurst residents (approximately 1200); that individualized program plans be developed for each resident with the participation of each class member or

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[3] The district court's opinion is reported at 446 F. Supp. 1295.

[4] The court entered judgment in favor of the defendants on the claim for money damages, and no appeal has been taken from that determination.

his next friend at the formulation and implementation stages; and that plans for the removal of Pennhurst residents to appropriate community based mental retardation programs, meeting individual needs and structured in the least restrictive, most integrated setting, be developed and submitted to the court. The order also provided for the appointment of a Special Master to supervise the planning and implementation of arrangements for placing Pennhurst residents elsewhere, and for the operation of Pennhurst until such placements were accomplished. It enjoined the County defendants from recommending future commitments of mentally retarded persons to Pennhurst, and forbade the Commonwealth defendants from placing additional persons there. It also established a "friend-advocate" program to represent the class members in monitoring the provision of community living arrangements. During the period of gradual phase-out of Pennhurst as a home for the mentally retarded, the Commonwealth defendants were ordered to takes steps to prevent any recurrence of some of the more egregious abuses of residents which the court found to have occurred in the past. The order further empowered the Master to establish a plan to provide alternative employment for all Pennhurst employees. An application for a stay of the March 17, 1978 order was denied by the district court,[5] and a panel of this court denied a stay pending appeal.

A panel of this court heard argument in the case on January 9, 1979. When no single opinion could command majority support, the case was set down for en banc disposition. Thereafter, renewed motions for a stay

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[5] *Halderman v. Pennhurst State Sch. & Hospital*, 451 F. Supp. 233 (E.D. Pa. 1978).

pending appeal were considered by the court en banc and on August 6, 1979 the court reserved judgment thereon, except that the order appealed from was "stayed to the extent that it shall not apply to transfers out of Pennhurst of any resident whose parents or guardian fails to sign a written consent to such transfer." In other respects, its implementation has gone forward pending appeal.

II. UNITED STATES INTERVENTION

The Commonwealth defendants, relying on *United States v. Solomon,* 563 F.2d 1121 (4th Cir. 1977), contend that the court erred in permitting the United States to intervene as a plaintiff. In *Solomon* the United States filed a complaint charging the State of Maryland with violating the rights of mentally retarded residents of the Rosewood State Hospital. The district court dismissed the action, holding that the United States lacked authority to bring it. The Fourth Circuit affirmed. In the instant case, equating intervention under Rule 24 with the original action in *Solomon,* the Commonwealth defendants urge that *Solomon* be followed and intervention by the United States disapproved. Of course, since the Halderman and PARC appellees defend the order appealed from on all the same grounds that the United States does, the resolution of the federal government's right to participate has no effect on the merits of the appeal. But its standing as an intervenor would determine the standing of the United States to seek or oppose Supreme Court review. Thus it is appropriate that we address that question.

In *Solomon* the Fourth Circuit acknowledged the numerous federal statutes evidencing a federal interest in, concern for, and activity with respect to the mentally

retarded.[6] It pointed out that no statute expressly authorized the United States to bring suit to challenge the alleged deprivation of the rights of the retarded. Reviewing and purporting to distinguish numerous cases sustaining the authority of the United States to sue in the absence of such express statutory authorization,[7] the court said:

> [W]e decline to hold that in the absence of specific authority the United States may sue in the instant case. *Youngstown Sheet & Tube Co. v. Sawyer,* 343 U.S. 579 (1952)—the so-called "Steel

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[6] These included §§1905(c) and (d) of Title XIX of the Social Security Act, 42 U.S.C. §1396(c), (d) (1976); the Education of the Handicapped Act, 20 U.S.C. §§1401-1461 (1976); the Developmental Disabilities Services and Facilities Construction Act, 42 U.S.C. §§2661-2666 and 2670-2677c, as amended by the Developmentally Disabled Assistance and Bill of Rights Act, Pub. L. No. 94-103, 89 Stat. 496, 42 U.S.C. §§6001-6081 (1976); the surplus food program, 7 U.S.C. §1431 (1976); and the school lunch program for institutionalized children, 42 U.S.C. §1761 (1976).

[7] *See, e.g., New York Times Co. v. United States,* 403 U.S. 713 (1971) (suit to enjoin publication of the Pentagon Papers); *In re Debs,* 158 U.S. 564 (1895) (suit to enjoin strike affecting interstate commerce); *United States v. San Jacinto Tin Co.,* 125 U.S. 273 (1888) (suit to set aside patent to land procured by fraud); *United States v. Bell Telephone Co.,* 128 U.S. 315 (1888) (suit to set aside invention patent obtained by fraud); *United States v. Brand Jewelers, Inc.,* 318 F. Supp. 1293 (S.D. N.Y. 1970) (suit to enjoin systematic due process violations in collection of consumer credit obligations). Perhaps not surprisingly, the strongest resistance to the standing of the United States to sue in the absence of an express statutory authorization has arisen out of its efforts to enforce civil rights. As the *Solomon* court put it:

> Congressional concern with federal-state relations in the area of civil rights is sufficiently great that we are reluctant to sustain nonstatutory executive acts in all but the clearest case.

> Seizure Case"—is one of the reasons for our decision. It raised the question of whether the President had the authority to seize the nation's steel industry in an effort to prevent a crippling steel strike during the Korean War. Because the President had no statutory or constitutional authority to seize the mills, the Court held that the seizure was illegal and improper.
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> The case is important here because of the light that it sheds on the doctrine of separation of powers. 563 F.2d at 1128.

We do not find persuasive the *Solomon* court's analogy between President Truman's nonjudicial seizure of the steel mills by military force and a judicial proceeding to obtain injunctive relief enforcing legislative policies in aid of the mentally retarded. There is all the difference in the world for separation of powers purposes between a naked exercise of executive power and executive branch

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563 F.2d at 1129. *See also United States v. School Dist. of Ferndale*, 400 F. Supp. 1122 (E.D. Mich. 1975), *aff'd in part and remanded in part*, 577 F.2d 1339 (6th Cir. 1978); *United States v. County School Bd., Prince George County*, 221 F. Supp. 93 (E.D. Va. 1963); *United States v. Biloxi Mun. School Dist.*, 219 F. Supp. 691 (S.D. Miss. 1963), and *United States v. Madison County Bd. of Educ.*, 219 F. Supp. 60 (N.D. Ala. 1963), *both aff'd on other grounds*, 326 F.2d 237 (5th Cir.), *cert. denied*, 379 U.S. 929 (1964). We see in the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§6001-6081 (1976) and §504 more concern for the handicapped than for federal-state relations. Congress must be aware, from the annual reports of the Attorney General (1974, p. 7374; 1975, pp. 85-86; 1976, pp. 111-112; 1977, pp. 161-162), that a litigation program intended to strengthen the rights of mentally retarded persons is an ongoing Justice Department activity. It has not reacted negatively.

resort to the judicial branch for relief which Congress has not expressly prohibited. The President is, after all, charged with the responsibility to "take Care that the Laws be faithfully executed . . ." U.S. Const. art. II, §3. When, in an effort to do so, he resorts to an Article III court under a recognized grant of federal jurisdiction such as 28 U.S.C. §1345, and that court finds no legislative prohibition against that resort, the lawsuit cannot reasonably be seen as an invasion of the powers of Congress. Before relief can be given in such a suit, one branch, the executive, must seek it, while a second branch, the judiciary, must agree that it is authorized by the law promulgated by a third branch. If the judiciary has, in an individual case, misconstrued the law, Congress can, constitutional pronouncements aside, change the rule for the future. If Congress wishes to withhold from the executive branch the civil remedies available under the Federal Rules of Civil Procedure, it can by specific legislation say so. Thus, we find unconvincing the separation of powers argument invoked by the *Solomon* court to reject executive branch enforcement of federal law.[8]

In this case, however, we need not decide whether absent the Halderman action the United States could independently have sued. The suit was already pending. Moreover, in its constitutional dimensions the suit was expressly authorized by 42 U.S.C. §1983. We hold that the initial plaintiffs have standing to enforce federal statutory claims as well. *See* pp. 110a-111a *infra.* Thus Congress has made the decision that someone could seek

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[8] *See* Gibbons, *The Interdependence of Legitimacy: An Introduction to the Meaning of Separation of Powers,* 5 Seton Hall L. Rev. 435 (1974).

the injunctive relief in question. Intervention presented no danger that the federal executive would initiating a lawsuit that Congress somehow never intended. Intervention was sought pursuant to Rule 24, Fed. R. Civ. P. 24, and there was ample justification for permitting it. Under Rule 24(b)(2), a district court may allow intervention when an applicant's claim or defense and the main action have common questions of law or fact. Rule 24(b) makes specific provision for intervention by governmental agencies interested in statutes, regulations, or agreements relied upon by the parties in the action. Here, as noted below, there is extensive federal legislation directed toward the well-being of the mentally retarded. Several executive branch agencies, especially the Department of Health, Education and Welfare (HEW), have important responsibilities under that legislation. Large amounts of federal funds flow to Pennsylvania from the federal government, and the United States is vitally interested in the enforcement of the conditions on which those grants are made. One such condition is compliance with governing federal law. Had the United States sought to do so, it could have brought suit to enforce the conditions attached to its grants.[9] Clearly, then, the district court did not abuse its discretion in permitting intervention under Rule 24.

III. FACTUAL FINDINGS

Neither the Commonwealth nor the County defendants take serious issue with the court's findings of fact respecting the abominable conditions to which Pennhurst residents have been subjected. They do contend, how-

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[9] *See United States v. Solomon*, 563 F.2d at 1129 (Butzner, J., concurring), and cases cited.

ever, that despite those findings there was no legal basis for the grant of any injunctive relief, and, alternatively, that the scope of the relief ordered was broader than was warranted by the facts or the law.

At the time of trial Pennhurst housed 1230 mentally retarded individuals, some of whom also suffered from physical disabilities. The residents are not mentally ill, have broken no laws, and are not a danger to others, although, in severe cases, some are unable to care for themselves. Mental retardation is an impairment in learning capacity and adaptive behavior, and is not treatable, like mental illness, by means of drugs or psychotherapy. While the mentally retarded do suffer educational difficulties, the level of their functioning can be improved by individualized training.

Residents come to Pennhurst either because of a commitment order from a state court, or by a "voluntary" admission initiated by a parent or guardian. In either case, the admission is arranged through Base Service Units, operated by the County defendants pursuant to the Pennsylvania Mental Health and Mental Retardation Act.[10] The Base Service Units are responsible for evaluating the needs of retarded individuals and determining the appropriate habilitative services.

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[10] Pa. Stat. Ann. tit. 50, §4301(d)(9) (Purdon 1969), states in relevant part:

> (d) . . . it shall be the duty of local authorities in cooperation with the department [of Public Welfare] to insure that the following mental health and mental retardation services are available:
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> * * *
>
> (9) Unified procedures for intake for all county services and a central place providing referral services and information.

In addition to large residential institutions like Pennhurst, Pennsylvania operates smaller and less isolated programs referred to as Community Living Arrangements (CLAs). The latter programs reflect a recognition of the principles of normalization for the habilitation of the retarded.[11] Under normalization principles, retarded persons are treated as much as possible like nonretarded persons. The purpose of such treatment is remediation of the delayed learning process so as to develop maximum potential in self-help, language, personal, social, educational, vocational and recreational skills. These remediation efforts, the trial court found, are, in general, much more likely to succeed in smaller living units which are closer to and more reflective of the normal society. In large separate isolated institutions like Pennhurst, however, the retarded generally suffer apathy, stunted growth, and even regression in the skills referred to. The effective result is the imposition or facilitation of increased retardation. Such large institutions, the court also determined, are more expensive to operate than community based alternatives. Perhaps for those and other reasons it had been the current intention of the Department of Public Welfare to transfer residents from Pennhurst to community residential facilities, supported by specialized services, by some time in the early 1980's. In the five county area, 530 retarded persons already live in CLAs, including 186 former Pennhurst residents.

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[11] For a description of the normalization principle in the care of the mentally retarded, *see* B. Nirje, *The Normalization Principle. Changing Patterns in Residential Services for the Mentally Retarded,* President's Committee on Mental Retardation, 231 (Rev. ed. 1976).

The district court also found that the environment at Pennhurst is not merely inconsistent with normalization principles, but is actually hazardous to residents. Because of the inadequacies in programming attributable to staff shortages, residents were found to have lost skills already learned. Organized programs of appropriate education and training were found to be inadequate or unavailable. Evaluations of resident progress do not meet minimum professional standards, and record keeping is inadequate.

Moreover, the Pennhurst environment was found to be unsanitary. There is often urine and excrement on the ward floors. Infectious diseases are common. Obnoxious odors and excessive noise permeate the institution. Most toilet areas do not have towels, soap or toilet paper. Injuries to residents by other residents or through self-abuse are common. Serious injuries inflicted by staff members, including sexual assaults, have occurred. Physical restraints, which may be physically harmful and which have caused injuries and at least one death, are resorted to more frequently than appropriate because of shortages of staff. Dangerous psychotropic drugs are used for purposes of behavior control and staff convenience rather than for legitimate treatment needs. Such drug misuse produces lethargy, hypersensitivity to sunlight, inability to maintain gait, and other disabilities. Seclusion in solitary confinement has been used to punish aggressive behavior which might not have occurred if a proper regimen of training were available. Diet control is not possible because residents dine in large group eating areas without adequate staff supervision.

The federal government is a substantial partner in the Commonwealth's and Counties' provision of services

generally available, although not always provided, to the mentally retarded. The Commonwealth Department of Welfare receives federal grants under both the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§6001-6081 (1976), and the Education for All Handicapped Children Act of 1975, 20 U.S.C. §§1401-1461 (1976). The Commonwealth, in turn, makes funds available to the Counties for purposes of developing and maintaining their CLAs. Thus it is clear that there are county based programs open and available to the mentally retarded which receive federal financial assistance. The trial court found that the Counties have made an insufficient effort to provide community based services to the retarded.[12] The population of Pennhurst has thus remained high, effectively precluding the residents from taking advantage not only of federally funded programs expressly intended for the care of the retarded, but also of various other federally funded facilities such as education and transportation.

The court held that the isolation at Pennhurst is attributable, across the board, to state action. It found that about half of the Pennhurst residents had been committed there by order of a Pennsylvania court, while the

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[12] The trial court found that because the Commonwealth has chosen to pay all of Pennhurst's costs not federally funded, while requiring the Counties to pay 10% of the cost of some community based services, the Counties have a financial incentive to send retarded residents to Pennhurst rather than attempting habilitation within the community, 446 F. Supp. at 1312. *See* Record Vol. 30, at 12.23 (testimony of Ms. E. A. Ballard). The County defendants urge that the finding that they have such a financial incentive is clearly erroneous. We need not resolve that question, since the basis on which we decide the legal issues is not dependent upon the motive of the Counties.

other half had been admitted upon application of a parent or guardian. Although the latter group of residents are referred to in some of the briefs as voluntary admittees, theoretically free to leave when of age, the court found that when a resident wishes to leave and the Pennhurst staff determines that there is no place for him in the community, or that he is not ready for community living, a petition for involuntary commitment is made. The court found, moreover, that many residents do not understand the available alternatives to institutionalization, or are physically unable to express an interest in leaving, or have no adequate alternative living arrangement. Thus the notion of voluntariness in admission and retention was found to be illusory.

IV. PREFERRED LEGAL BASES FOR RELIEF

Appellants, as we noted above, do not quarrel with the facts; they dispute only the legal significance of those facts. They reject both the court's conclusion that the mentally retarded have a legal right to treatment or habilitation and its conclusion that treatment or habilitation must be provided in the least restrictive environment. Moreover, even assuming that these rights exist, appellants challenge the court's injunctive order as overbroad. We consider in turn each of these objections.

The district court's determination that appellees have a right to treatment was predicated upon constitutional, federal and state statutory grounds. The federal courts have long been directed to decide whether causes of action can be supported on statutory grounds before they adjudicate constitutional law issues.[13]

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[13] *Hagans v. Lavine*, 415 U.S. 528, 543 (1974); *Siler v. Louisville & Nashville R.R. Co.*, 213 U.S. 175, 193 (1909).

Moreover, while federal courts can interpret federal legislation definitively, subject only to Supreme Court review, their interpretation of a state statute arguably supporting the judgment might be rejected by the state's courts. The preferred order, therefore, is to turn first to the federal statutory issues. Thereafter, we will consider state statutory grounds for the trial court's decision.

V. THE RIGHT TO TREATMENT OR HABILITATION[14]

A. Federal Statutory Law

In their second amended complaint, appellees asserted a cause of action under the Developmentally Disabled Assistance and Bill of Rights Act, Pub. L. No. 94-103, 89 Stat. 486, *codified at* 42 U.S.C. §§6001-6081 (1976) [hereinafter "the Act"]. The trial court did not reach the question of defendants' possible liability under this statute. The parties have nevertheless supplied this court with detailed briefing on the statute. We are persuaded that the Act provides the mentally retarded with a right to treatment.

The Act was passed in 1975 as an amendment to the Developmental Disabilities Services and Facilities

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[14] Throughout this section the terms "treatment" and "habilitation" will be used interchangeably. Strictly speaking, since mental retardation is not a curable disability, the term "treatment" is inappropriate. Rather, "habilitation," which refers to "that education, training and care required by retarded individuals to reach their maximum development," 446 F. Supp. at 1298, is the more appropriate term. Nevertheless, because the relevant statutory and constitutional sources typically apply both to the mentally ill—who can be treated—and to the mentally retarded, who can only be educated, trained and cared for, we will employ both words interchangeably.

Construction Act. It established particular rights and benefits for the developmentally disabled, a class of persons which included the mentally retarded. 42 U.S.C. §6001 (7) (A) (i). Among those was a right to the least restrictive environment, about which we will have more to say in Section VI A below. In addition, however, the Act expressly provided that the developmentally disabled have a right to treatment or habilitation. In the so-called Bill of Rights section, 42 U.S.C. §6010, Congress made plain its intention to establish a right to treatment.[15]

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[15] §6010. Congressional findings respecting rights of developmentally disabled

Congress makes the following findings respecting the rights of persons with development disabilities:

(1) Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities.

(2) The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.

(3) The Federal Government and the States both have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that—

(A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons; or

(B) does not meet the following minimum standards:

(i) Provision of a nourishing, well-balanced daily diet to the persons with developmental disability being served by the program.

(ii) Provision to such persons of appropriate and sufficient medical and dental services.

(iii) Prohibition of the use of physical restraint on such persons unless absolutely necessary and prohibition of the use

Congress found that "[p]ersons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities." 42 U.S.C. §6010-

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of such restraint as a punishment or as a substitute for a habilitation program.

(iv) Prohibition on the excessive use of chemical restraints on such persons and the use of such restraints as punishment or as a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation for such persons.

(v) Permission for close relatives of such persons to visit them at reasonable hours without prior notice.

(vi) Compliance with adequate fire and safety standards as may be promulgated by the Secretary.

(4) All programs for persons with developmental disabilities should meet standards which are designed to assure the most favorable possible outcome for those served, and—

(A) in the case of residential programs serving persons in need of comprehensive health-related, habilitative, or rehabilitative services, which are at least equivalent to those standards applicable to intermediate care facilities for the mentally retarded promulgated in regulations of the Secretary on January 17, 1974 (39 Fed. Reg. pt. 11), as appropriate when taking into account the size of the institutions and the service delivery arrangements of the facilities of the programs;

(B) in the case of other residential programs for persons with developmental disabilities, which assure that care is appropriate to the needs of the persons being served by such programs, assure that the persons admitted to facilities of such programs are persons whose needs can be met through services provided by such facilities, and assure that the facilities under such programs provide for the humane care of the residents of the facilities, are sanitary, and protect their rights; and

(C) in the case of nonresidential programs, which assure the care provided by such programs is appropriate to the persons served by the programs.

(1). Moreover, both "[t]he Federal Government and the States . . . have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that—(A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons . . ." 42 U.S.C. §6010(3) (A). It is hard to see how Congress could have been any more precise in revealing its intention to confer a right to treatment or habilitation.

Another section of the Act reaffirms the right to treatment. Section 6063 provides that any state which wishes to take advantage of the subchapter must submit a plan to the Secretary of HEW. That plan must contain a program designed, *inter alia,* "to improve the quality of care and the state of surroundings of persons for whom institutional care is appropriate . . ." 42 U.S.C. §6063(b)-(20) (B). While this section was delected in the 1978 revision of the Act, it did apply until that date and retains legal significance for purposes of this litigation. Moreover, the revised statute contains a section requiring states to conform their plans to the dictates of the Bill of Rights provision, section 6010. *See* 42 U.S.C. §6063-(b) (5) (C) (Supp. 1979).

The legislative history of Pub. L. No. 94-103 also supports the recognition of a statutory right to treatment for the mentally retarded. Congressman Carter, in introducing H.R. 4005 (later enacted as Pub. L. No. 94-103) in the House, stated that among its many purposes "[t]his legislation . . . directs that States should devote attention to improving the facilities and surroundings of institutions where people have been appropriately institutionalized." 121 Cong. Rec. 9976 (1975). The bill was introduced in the Senate as S. 462. 121 Cong. Rec. 16,

470. Senator Stafford, discussing the purpose of Title II—the Bill of Rights—stated "Title II was added to the bill to assist in the protection of the rights guaranteed under our constitution for those individuals that will require institutionalization . . ." *Id.* at 16,516. Senator Javits added that "Congress should reaffirm its belief in equal rights for all citizens—including the developmentally disabled. Congress should provide the leadership to change the tragic warehousing of human beings that has been the product of insensitive Federal support of facilities providing inhumane care and treatment of the mentally retarded." *Id.* at 16,519. Senator Cranston observed that while the bill endorsed deinstitutionalization, it "recognize[d] that the need for some long-term residential programs will remain. The bill specifically provides that where institutional programs are appropriate, adequate support should be planned for them so that necessary treatment and habilitation programs can be given residential patients to develop their full potential." *Id.* at 16,520. Senator Schweiker described one of the requirements of the proposed legislative Bill of Rights as "[h]umane care, treatment, rehabilitation, and protection in residential facilities . . ." *Id.* at 16,522.

The bill went to conference, in part because the Senate bill contained an expanded version of Title II—specifying in great detail the standards for appropriate care—with which the House did not concur. The Conference Committee compromised on details, and produced the more general, yet equally forceful Bill of Rights provisions, now codified in section 6010. A right to treatment was, as we noted above, specifically proclaimed. Thus, the Conference Report for the bill states that "the developmentally disabled have a right to appropriate treat-

ment, services and habilitation . . ." H. R. Conf. Rep. No. 94-473, 94th Cong., 1st Sess. 42 (1975); U.S. Code Cong. & Ad. News 943, 961. In addition, Senators Javits, Schweiker and Williams, in approving the Conference Report, all called attention to the critical role of the right to treatment. 121 Cong. Rec. 29,820-21. We therefore hold that the Developmentally Disabled Assistance and Bill of Rights Act grants to the mentally retarded a right to treatment and habilitation.

We further hold that retarded persons have a private right of action under the Act. To date, only one other court has considered whether private litigants may enforce the rights granted under the Act. In *Naughton v. Bevilacqua,* 458 F. Supp. 610 (D.R.I. 1978), Judge Pettine concluded that there was a private right of action. Plaintiffs in *Naughton* were a mentally retarded, schizophrenic patient and his father. They brought suit for injunctive relief and damages, alleging that the child had sustained injuries as a result of drugs administered to him in a Rhode Island institution. Among their several causes of action, plaintiffs asserted a claim under 42 U.S.C. §§6001-6081.

The court, reviewing the statute, concluded that it intended to convey a private right of action. Judge Pettine offered several arguments supporting his view of Congressional intent. First, he noted, section 6010, the Bill of Rights provision, has two sections: the first "declares the right to appropriate treatment"; the second "provides that federal funds are available only to programs that meet certain basic minimum standards and offer 'appropriate' treatment." 458 F. Supp. at 616. "This dichotomy in sec. 6010," the court reasoned, "suggests that denial of funds is not the only mechanism to

enforce the declared statutory rights." *Id.* In addition, the court noted that the Conference Report expressly states that " 'this right [to receive appropriate treatment] should be protected and assured by the Congress and the courts.' " *Id.* (quoting [1975] U.S. Code Cong. & Ad. News 961). Furthermore, participating states are required under the Act "to establish an independent agency 'to protect and advocate the rights of persons with developmental disabilities, and . . . to pursue *legal,* administrative, and other appropriate remedies to insure the protection of the rights of such persons who are receiving treatment, services or habilitation within the State. . . .' " *Id.* (quoting 42 U.S.C. §6012(a)). As the court observed, "[t]he enforcement of individual rights . . . cannot be achieved solely by withholding federal funds; not only is the Secretary incapable of investigating every violation, but the Secretary may quite properly be unwilling to withhold funds for a single violation. Thus, the advocacy agency and a private right of action are crucial to protect the rights secured by the Act." *Id.* Finding that the developmentally disabled were the "especial benefi[ciaries]" of the Act, that private suits would effectuate the policies of the statute, and that they would not infringe traditional state prerogatives, the *Naughton* court concluded that there was a private right of action under 42 U.S.C. §§6001-6081.

We find the *Naughton* court's analysis persuasive. A private right of action eminently satisfies the standards articulated in *Cort v. Ash,* 422 U.S. 66, 78 (1975).[16] As

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[16] *Cort v. Ash* set forth four relevant factors to be considered in determining whether a private remedy is implicit in a statute: whether the plaintiffs are especial beneficiaries of the statute, whether there is any indication of legislative intent to create a

developmentally disabled persons, the mentally retarded undoubtedly qualify as, "especial benefi[ciaries]" of the section 6010 grant of a right to treatment. In addition, the Conference Report recognized the desirability of enforcement of the Act, in part, by the courts. Moreover, a private right of action would surely further the purposes of the Act. By permitting private suits, courts would facilitate improvements in the delivery of services to the disabled without forcing the federal government to resort to the drastic remedy of a cut-off of funds.

It may be argued, however, that while the first three *Cort v. Ash* criteria are satisfied, the implication of a private right of action would infringe basic state prerogatives, and transgress the bounds of federal lawmaking competence, inasmuch as mental health policies have always been within the states' traditional police power authority. We are unpersuaded by that argument. While providing for the health and well-being of the citizenry is surely a legitimate state function, Congress's recognition of a right to treatment in section 6010 is not a simple displacement of that admittedly basic state concern.

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private remedy, whether a private remedy would further the policies of the statute, and finally whether the cause of action is one traditionally relegated to the states. *See Cannon v. Univ. of Chicago*, 47 U.S.L.W. 4549 (May 14, 1979) (implying private right of action under Title IX of the Education Amendments of 1972, 20 U.S.C. §1681 (1976), a civil rights statute); Note, *Implied Rights of Action to Enforce Civil Rights: The Case for a Sympathetic View*, 87 Yale L.J. 1378 (1978). *Cf. Touche Ross & Co. v. Redington*, 47 U.S.L.W. 4732 (U.S. June 18, 1979) (refusing to imply private action for damages under §17(a) of the Securities and Exchange Act of 1934, clearly not a civil rights statute).

In *Ingraham v. Wright,* 430 U.S. 651, 673 (1977), the Supreme Court said that among the liberties protected by the fourteenth amendment is "a right to be free from and to obtain judicial relief for unjustified intrusions on personal security." Section 5 of the fourteenth amendment vests Congress with authority "to enforce by appropriate legislation, the provisions of this article." In Section 6010, Congress has legislated with respect to the state intrusions on personal security of the developmentally disabled.[17] Thus, in providing specific guarantees for a particular affected group, Congress' action is consistent with the Supreme Court's recognition of the broad underlying right protected against impairment by the state through the fourteenth amendment. Section 6010 does not go beyond what has been judicially declared to be the limits of the fourteenth amendment but clearly is within those bounds.[18] Since the rights de-

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[17] That Congress intended in §§6001-6081 to enforce recognized constitutional rights is amply borne out by the legislative history of the Act. *See* 121 Cong. Rec. 16,516 (1975) (remarks of Sen. Stafford). Moreover, Senator Javits, speaking in support of the measure, cited *Wyatt v. Stickney,* 344 F. Supp. 387 (M.D. Ala. 1972); 344 F. Supp. 373 (M.D. Ala. 1972), *enforcing,* 325 F. Supp. 781 (M.D. Ala. 1971), *affirmed in relevant part, remanded in part, and decision reserved in part, Wyatt v. Aderholt,* 503 F.2d 1305 (5th Cir. 1974) (Constitution guarantees persons civilly committed to state mental institutions a right to treatment and granting relief does not invade exclusive province of state legislature), as an articulation of "constitutionally required minimum standards for the care and treatment of mentally retarded patients." *Id.* at 16,519.

[18] *Cf. Oregon v. Mitchell,* 400 U.S. 112 (1970); *Katzenbach v. Morgan,* 384 U.S. 641, 658 (1966) (§4(e) of Voting Rights Act of 1965 is proper exercise of congressional powers under §5 of fourteenth amendment). *See generally Cox, Foreword: Constitu-*

scribed in section 6010 are specified pursuant to section 5 of the fourteenth amendment, implication of a private cause of action from that statute rests upon the same constitutional footing. Thus we are not dealing with the implication of a private cause of action from a congressional enactment justified only by the spending power of the federal government, and we need not address the question whether such a statute could ever provide the predicate for private substantive rights. As the Supreme Court acknowledged in another context, Congress may, under section 5, establish certain restrictions that might otherwise implicate the prerogatives of the states.[19]

We also note that any suggestion that private enforcement of the Act usurps basic State concerns, is vitiated by the structure of the Act itself. For example, section 6063(b)(20)(B), which until 1978 required states to produce a plan providing for improved quality of care, was applicable to all those states "desiring to take advantage of this subchapter." 42 U.S.C. §6063(a). Congress thus invoked its spending clause powers to condition the grant of federal monies on the provision by the states of adequate care. Pennsylvania has accepted federal funds provided pursuant to the Act.[20] Whatever

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tional Adjudication and the Promotion of Human Rights, 80 Harv. L. Rev. 91 (1966).

[19] *See Fitzpatrick v. Bitzer*, 427 U.S. 445 (1976); *Usery v. Allegheny County Inst. Dist.*, 544 F.2d 148, 155 (3d Cir. 1976), *cert. denied*, 430 U.S. 936 (1977); *cf. National League of Cities v. Usery*, 426 U.S. 833 (1976).

[20] *See* Commw. of Pa., Governor's Executive Budget 1979-80 at 638. We need not decide whether the obligations of §6010 apply even to those states which do not accept federal funds under the Act. As to those states, this spending clause analysis would not ap-

argument it might otherwise have had were it faced with an unexpected set of federal obligations is refuted by its obvious willingness to accept the benefits of the Act.[21]

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ply. For the reasons elaborated at pp.113a-114a, *supra*, and p. 119a n. 21 *infra*, we doubt that the concerns for state autonomy—indicated in *National League of Cities*—would prevail over a congressional announcement of fourteenth amendment policy. But we need not address that issue here. It is sufficient for our purposes to note that Pennsylvania has accepted federal funds and has thus consented to federally mandated standards for the treatment and habilitation of the developmentally disabled.

[21] *Cf. Developments in the Law—Zoning*, 91 Harv. L. Rev. 1427, 1617 (1978) ("nothing in *National League of Cities* or in related principles of federalism would prevent Congress from using the spending power to require that states receiving federal funds for the development and administration of land use programs abide by federal specifications"). For these same reasons we would reject, were it made, any contention that §§6001-6081 are unconstitutional under *National League of Cities*. *Fitzpatrick v. Bitzer*, 427 U.S. 445 (1976), recognizes that *National League of Cities* is inapplicable to legislation promulgated pursuant to §5 of the fourteenth amendment, 427 U.S. at 453-56. This court reached the same conclusion with respect to the Equal Pay Act. *Usery v. Allegheny County Inst. Dist.*, 544 F.2d 148 (3d Cir. 1976) *cert. denied*, 430 U.S. 946 (1977). Moreover, we note that the Supreme Court itself has chosen to read the state reserved powers language in *National League of Cities* narrowly. In *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389 (1978), the Court held that cities and subdivisions of a state that engage in anticompetitive practices without authorization are subject to federal antitrust liability. The *Lafayette* Court paid scant attention to *National League of Cities*, thus suggesting that even under the commerce clause federal statutes may be enforced against the states. *See* 435 U.S. at 423-24 (Burger, C.J., concurring in Part 1 of the opinion and in the judgment) ("[t]he *National Lague of Cities* opinion focused its delineation of the 'attributes of sovereignty' . . . on a determination as to whether the State's interest involved '"function essential to

Finally, we have recently decided that a private right of action exists for the enforcement of section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794 (1976) —another statute designed to improve the lives of handicapped persons. *National Association for the Advancement of Colored People v. The Medical Center, Inc.*, 599 F.2d 1247, 1258-59 (3d Cir. 1979).[22] We did not feel, in that case, that the traditional police power duties of the states foreclosed a private right of action. In view of these considerations, then, we hold that appellees have

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separate and independent existence.'' ' . . . It should be evident, I would think, that the running of a business enterprise is not an integral operation in the area of traditional government functions.''). (Quoting *National League of Cities v. Usery*, 426 U.S. at 845, quoting *Coyle v. Oklahoma*, 221 U.S. 559, 580 (1911)).

The author of this opinion notes that even assuming, arguendo, that the provision of habilitation is within the sphere of the states' autonomy, that does not end the matter; ''[t]o determine whether the federal action is unconstitutional requires a balancing of the federal interests, on the one hand, against the degree of federal intrusion upon state autonomy on the other.'' *Developments in the Law—Zoning*, 91 Harv. L. Rev. 1427, 1613 n. 159 (1978). *See National League of Cities*, 426 U.S. at 852-53 (distinguishing *Fry v. United States*, 421 U.S. 542 (1975), which upheld a temporary freeze on wages of state and municipal employees, in part on the ground that ''[t]he enactment at issue there was occasioned by an extremely serious problem. . . .''); *id.* at 856 (Blackmun, J., concurring). Here, Congress has found that certain rights must be recognized in order that disabled persons realize their basic constitutional liberties. The balance, in my view, plainly favors the legislation.

[22] In *Southeastern Community College v. Davis*, 47 U.S.L.W. 4689, 4691 n. 5 (June 11, 1979), the Supreme Court expressly avoided deciding whether there exists a private right of action under section 504. The Court went on, however, to reach the merits of the plaintiff's cause of action.

standing to sue to enforce the Bill of Rights provisions of the Act.

One court, we note, has held that claims under the Act must be brought in state court. *United States v. Solomon,* 563 F.2d at 1125. The *Solomon* court acknowledged that the Conference Report on the Act stated that the right to treatment "should be protected and assured by the Congress and the courts." 563 F.2d at 1124. It held, however, that this language "manifestly refers to a state judicial forum and not to a federal judicial forum where the United States customarily sues." *Id.* at 1125.

With deference to the Fourth Circuit, we see nothing manifest in the Conference Report supporting that court's interpretation. If anything, the legislative history reflects a Congressional belief that States were not spending funds for the disabled effectively. The Developmentally Disabled Assistance and Bill of Rights Act sought to change the traditional spending habits of the states. It is most unlikely that Congress intended those changes to be enforceable only in state courts.[23] We would find it quite anomolous in the absence of a clear congressional expression to hold that a federal statute created a cause of action arising under federal law, but enforceable only in the state courts and not under 28 U.S.C. §1331 (1976).

Accordingly, we hold that appellees have a federal statutory right to habilitation, that they may sue to en-

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[23] In Part II, pp. 101a-102a *supra,* we rejected the *Solomon* court's position that the United States was precluded from judicial enforcement of the Developmentally Disabled Assistance and Bill of Rights Act.

force that right, and that such suit is properly lodged in federal court.

B. State Law

As an alternative ground for a right to adequate habilitation, appellees point to sections 101-704 of Pennsylvania's Mental Health and Mental Retardation Act of 1966 [hereinafter MH/MR Act of 1966], Pa. Stat. Ann. tit. 50, §§4101-4704 (Purdon 1969). The trial court accepted this contention, relying principally upon section 201 of the Act. That section, which establishes the responsibilities of the Department of Public Welfare, provides in pertinent part:

> The department shall have power, and its duty shall be:
>
> (1) To assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them . . .

Pa. Stat. Ann. tit. 50, §4201. The court held that this section grants retarded persons an affirmative right to minimally adequate habilitation. 446 F. Supp. at 1322. Moreover, it noted, the County defendants share in this statutory duty to supply adequate treatment. *Id.* at 1322-23.

Section 201 refers to the State's "duty" to "assure" the "availability . . . of adequate mental health and mental retardation services for all persons who need them . . ." Pa. Stat. Ann. tit. 50, §4201 (1). That language is broad and determined: The obligation to provide services to the mentally handicapped on the basis of need. Had the Commonwealth intended to offer only confinement

without more, it would hardly have spoken in terms of "adequate . . . services." *Id.*

Our reading of the statutory language is amply supported by the legislative history of the MH/MR Act of 1966. Speaking on behalf of the Act in the Pennsylvania Senate, Senator Pechan elaborated its fundamental habilitative purposes.

> The object of this legislation is to make it possible for every mentally disabled person to receive the kind of treatment he needs, when and where he needs it. It will make those services available to every citizen in every community which are now available only to a lucky few, in the more progressive communities. It will open more beds in the local general hospitals. It will make available the services of psychiatrists and psychologists, of psychiatric nurses and social workers, of specially trained occupational therapists, of speech and hearing therapists, of activities directors and of child care workers. It will supplement the benefits of therapy with daytime and evening programs of activity which will call back to reality the erring mind, which will recreate and strengthen the ties which bind one human being to another and make us comfortable in each others' company. It will provide productive activity for those who can work only in a sheltered situation, and for those who are able, it will prepare them to go back to the customary world of business and industry, or to go forth into it for the first time, as the case may be. For those in acute distress, service will be available twenty-four hours a day, and the violent will find protective care instead of the harsh custody of jail.

1966 Pa. Legis. J., 3d Spec. Sess.—No. 33, 76 (Sept. 27, 1966). The Act, Senator Pechan declared "will [make] it . . . easy for a mentally disabled person to find the treatment he needs . . ." *Id.* Senator Sesler concurred, *id.* at 77, and added:

> When you realize that practically one out of ten of every Pennsylvanian has some problem in mental health, you will realize how vast the scope of this problem is. However, I think, we now have sketched in broad, general terms the framework of a program which can provide a continuum of services—out-patient, in-patient, diagnostic treatment, evaluation and research, a procedure of commitment under almost all conceivable types of circumstances.

Id.

Those few courts which have previously considered the MH/MR Act of 1966 have also gleaned from it a right to treatment for the mentally handicapped. In *In re Joyce Z.*, 123 Pitt. L. J. 181 (1975), the Common Pleas Court for Allegheny County held that a profoundly retarded child had, under section 201 of the Act, a right to treatment. 123 Pitt. L. J. at 187. The court quoted the relevant language of section 201 and declared, "These are brave words. We mean to see that the State, acting through the Department of Public Welfare, abides by them." *Id.* In view of the statutory right to treatment, the court held that Pennsylvania was obliged to provide casework services to the child, her parents, and her foster parents, together with financial assistance to meet the child's physical needs. *Id.* at 190. *Joyce Z* establishes, as well, that the statutory right to treatment is under Pennsylvania law judicially enforceable in a private action.

To like effect was Chief Judge Lord's decision in *Eubanks v. Clarke,* 434 F. Supp. 1022 (E.D. Pa. 1977). There, relying in part on section 201 of the MH/MR Act of 1966, Judge Lord held that the plaintiff, an involuntarily committed schizophrenic, had a "state law right to treatment or release." 434 F. Supp. at 1027. Similarly, in *Hoolick v. Retreat State Hospital,* 24 Pa. Commw. Ct. 218, 354 A.2d 609 (1976), *aff'd* 476 Pa. 317, 382 A.2d 739 (1978), a Pennsylvania court described the MH/MR Act of 1966 as envisioning a "comprehensive program for the care, treatment and rehabilitation of mentally disabled and mentally retarded persons . . ." 24 Pa. Commw. Ct. at 220, 354 A.2d at 611.[24]

Despite the apparent meaning of section 201, and the plain intentions of the state legislature,[25] several of

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[24] *See County of Allegheny v. Commw. Dept. of Pub. Welfare,* 33 Pa. Commw. Ct. 267, 269, 381 A.2d 1014, 1016 (1978) (squaring its own holding with the mandate of *Joyce Z.* and *Hoolick* which, in the court's view, required the availability of adequate mental retardation facilities). *Cf. Doe v. Colautti,* 592 F.2d 704, 711-12 (3d Cir. 1979) (citing the MH/MR Act of 1966, and Pennsylvania's "allocation of an extraordinarily large portion of its budget to the treatment of the mentally ill," as reasons to eschew creating new suspect classification for protection of mentally handicapped).

[25] While not expressly covering persons who are mentally retarded but not mentally ill, Pennsylvania's Mental Health Procedures Act, Pa. Stat. Ann. tit. 50, §§7101-7503 (Purdon) (Supp. 1979) promulgated in 1976, also reflects the state's recognition of a need for treatment. Section 102 of the Act provides, in pertinent part:

> §7102. Statement of policy
>
> It is the policy of the Commonwealth of Pennsylvania to seek to assure the availability of adequate treatment to persons who are mentally ill, and it is the purpose of this act to

the appellants object to the trial court's reliance on the MH/MR Act of 1966. The Commonwealth and the Counties contend that section 509(5) of the Act belies any duty on their part to provide treatment. Section 509(5) empowers the Department of Public Welfare to distribute grant monies to the Counties where sufficient funds have not been appropriated by the State.

> In the event that sufficient funds to pay the full amount of the grants to which the counties may be entitled under the provisions of this section have not been appropriated, to distribute State funds among the counties by a formula reasonably designed to achieve the objectives of this act, provided however, that in such event the counties' financial obligations under this act shall be reduced in accordance with the same formula and the counties shall be required to provide only those services for which sufficient funds are available.

Pa. Stat. Ann. tit. 50, §4509(5). The Commonwealth contends that since services to the retarded can be reduced in light of insufficient funding, there cannot be "an unconditional right to those services." Brief for Commonwealth Appellants at 31. The Counties, on the other hand, rely on this section in making their argument that any duty to provide treatment rests solely on the state, and not them. Brief for Suburban County Appellants at 24-25.

> establish procedures whereby this policy can be effected. . . . Treatment on a voluntary basis shall be preferred to involuntary treatment; and in every case, the least restrictions consistent with adequate treatment shall be employed.

Pa. Stat. Ann. tit. 50, §7102.

We reject these contentions. Section 509(5) hardly relieves the Commonwealth of its statutory duties under section 201. Section 509(5) delineates nothing more than the method by which insufficient funds are to be distributed. It states the apparent truism that where the state has failed to provide Counties with full funding, the Counties need not supply a constant level of services. This may, to be sure, imply that the right to treatment is not "unconditional." But no right is without some limitations. All that section 201 promises, and all that we hold, is that to the extent Pennsylvania maintains facilities for the mentally handicapped, those facilities must provide adequate treatment or habilitation.

Nor do we agree with the Counties that section 509(5) absolves them of any duty to provide treatment. The MH/MR Act of 1966 contemplated a joint venture between the Commonwealth and its subdivisions, the Counties, in the provision of services to the mentally handicapped. As Senator Sesler stated, in supporting the Act:

> We want to make it clear, for the record, that we are giving this responsibility to our County Governments, and we are giving them a great deal of money. One of the amendments just adopted today has provided that the State will have to reimburse the counties for ninety per cent of the cost of the program. We are giving them a certain degree of freedom. However, we must remind them that the counties had a program of control for taking care of the mentally ill, prior to 1937, when they failed to do an adequate job. It may be that they lacked the finances at that time, and that they lacked the public's support. However, today, I think that the pub-

> lic's support is there. I trust that the Commonwealth will be there with the adequate finances. . . .
>
> I hope that we can focus attention on the local level, because if there was ever an example of a cooperative effort, which involves so many citizens and private groups as this legislation, I do not know what it is. We are going to give it control down on the local level; we are giving it a flexible degree of control. So, I am saying today—at least, I, speaking for myself—that we are charging County Governments with this tremendous responsibility. We hope that they will take these words to heart. . . .

1966 P. Legis. J., 3d Spec. Sess.—No. 33, 77 (Sept. 27, 1966). Section 509(5) in no way undercuts the intended partnership of the Counties and the Commonwealth.

The Counties contend, however, that while they may have *some* responsibilities under the Act to provide habilitation to the retarded, those responsibilities are exhaustively specified in section 301(d), and no other duties—such as habilitation at institutions or community living arrangements—can be imposed upon them.[26] We

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[26] Section 301(d) of the Act provides:

> Subject to the provisions of sections 508 and 509(5) it shall be the duty of local authorities in cooperation with the department to insure that the following mental health and mental retardation services are available:
>
> (1) Short term inpatient services other than those provided by the State.
>
> (2) Outpatient services.
>
> (3) Partial hospitalization services.
>
> (4) Emergency services twenty-four hours per day which shall be provided by, or available within at least one of the types of services specified heretofore in this paragraph.

reject this suggestion. It is true that section 301 (d) sets forth specific duties for the Counties. Nevertheless, the Counties' mandate under the Act is much broader. Section 301 (a), for example, states, in pertinent part:

> The local authorities of each county separately or in concert with another county or counties, as the secretary may approve, shall establish a county mental health and mental retardation program for the prevention of mental disability, and for the diagnosis, care, treatment, rehabilitation and detention of the mentally disabled and shall have power to make appropriations for such purposes.

Pa. Stat. Ann. tit. 50, §4301 (a). This section directs that local authorities establish a "mental health and mental retardation program for the . . . treatment, rehabilitation and detention of the mentally disabled . . ." *Id.* Thus, although section 4301 (d) specifies certain facilities for which the Counties will be principally responsible, the Act as a whole contemplates County participation in all facets of the state's provision of services. Indeed, in the

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(5) Consultation and education services to professional personnel and community agencies.

(6) Aftercare services for persons released from State and County facilities.

(7) Specialized rehabilitative and training services including sheltered workshops.

(8) Interim care of mentally retarded persons who have been removed from their homes and who having been accepted, are awaiting admission to a State operated facility.

(9) Unified procedures for intake for all county services and a central place providing referral services and information.

(Footnote omitted). Pa. Stat. Ann. tit. 50, §4301(d).

case of Pennhurst itself, the Counties have joined inextricably in the state's provision—or lack of provision—of treatment. As we noted in Part III above, the Counties arrange for admission to Pennhurst through their operation of Base Service Units. Often, the district court found, the County Base Service Units fail to investigate alternatives to institutional placements, thereby consigning the mentally retarded to inadequate living conditions. 446 F. Supp. at 1313. Having thus participated for so long in the institutional practices at Pennhurst, the Counties cannot at this late date escape—by pointing the finger of responsibility elsewhere—the statutory duty to provide adequate habilitation.

Accordingly, we hold that the appellees have a state statutory right to habilitation, that they may sue to enforce that right, and that a federal court has pendent jurisdiction to enforce that right which was properly exercised in this instance.

VI. THE RIGHT TO THE LEAST RESTRICTIVE ENVIRONMENT

Having concluded that appellees have a right to treatment, we turn to a consideration of the setting in which that treatment must be provided. Plaintiffs contend that the state is obliged to provide habilitation in an environment that infringes least on the personal liberties of the mentally retarded. The trial court agreed, predicating the decision exclusively upon constitutional grounds. The court reasoned that because "[a]ll admissions to state facilities . . . entail an infringement on fundamental rights and freedom . . . [,] due process demands that if a state undertakes the habilitation of a retarded person, it must do so in the least restrictive set-

ting consistent with that individual habilitative needs." 446 F. Supp. at 1319. While there is substantial caselaw support for the trial court's constitutional position,[27] our resolution of the present controversy on statutory grounds obviates the necessity for consideration of this constitutional issue. Two federal statutes were relied upon in the district court as sources of a right to the least restrictive environment: The Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§6001- 6081 (1976), discussed at pp. 106a-119a *supra,* and section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794 (1976).[28]

A. The Developmentally Disabled Assistance and Bill of Rights Act

In Part V A above we addressed the origins and development of this statute. We noted there that the Act enunciates a right to treatment for the developmentally disabled. In addition to that right, however, the Act expresses a clear congressional preference for deinstitutionalization. Section 6010 states plainly that "the treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty." 42 U.S.C. §6010(2). State plans were

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[27] *See* note 38, *infra.*

[28] As noted above, *supra,* the trial court did not reach the question of liability under §6001 and while it found liability under §504, the court did not rely expressly on that statute in developing a least restrictive alternative analysis. Since we also do not rely on §504 nor on the Constitution for our holding, we have, of necessity, departed somewhat from the trial court's approach.

required, until 1978, to "contain a plan designed . . . to eliminate inappropriate placement in institutions of persons with developmental disabilities . . ." 42 U.S.C. §6063 (b) (20). Moreover, they were obliged to

> support the establishment of community programs as alternatives to institutionalization and support such programs which are designed to provide services for the care and habilitation of persons with developmental disabilities, and which utilize, to the maximum extent feasible, the resources and personnel in related community programs to assure full coordination with such programs and to assure the provision of appropriate supplemental health, educational, or social services for persons with developmental disabilities . . .

42 U.S.C. §6063 (b) (23). Finally, the plans were required to provide

> the maximum utilization of all available community resources including volunteers serving under the Domestic Volunteer Service Act of 1973 (Public Law 93-113) and other appropriate voluntary organizations except that volunteer services shall supplement, but shall not be in lieu of, services of paid employees . . .

42 U.S.C. §6063 (b) (26).

The legislative history of the Act supports the preference for deinstitutionalization. Introducing the bill in the House, Congressman Carter stated:

> This bill encourages the States to adopt programs of deinstitutionalization. We, as a committee, are well

> aware that treatment of the developmentally disabled should be conducted in that person's community without unnecessarily institutionalizing him. Funds have been earmarked for this purpose.

121 Cong. Rec. 9976 (1975). Referring to another bill, Congressman Carter said its

> "main thrust . . . was to minimize the necessity for institutionalization. It has come to the attention of the committee that there needs to be particular attention paid to the same basic problem as it applies to the developmentally disabled. There seems to be a tendency in some areas to resort to inpatient treatment when other means of accomplishing the treatment might be possible. Having recognized that this misuse of facilities has taken place, it is now necessary that we take steps to review and correct the mistakes already made. The bill [H. R. 4005] requires that States spend a specified percentage of allotments to tackle the problem and see that those who have been inappropriately institutionalized be handled in some other manner.

Id. at 9977. Congressman Biaggi noted that "[t]he bill . . . recognizes the trend toward deinstitutionalization and propose[s] increased appropriations to carry out demonstration programs which will affect [sic] this goal." *Id.* at 9978. He added that "the cost of home health care can be . . . up to five times less expensive than care in a specialized facility." *Id.*

The House version of the bill passed by a vote of 398-5. *Id.* at 9981-82. As noted above, it was introduced in the Senate as S. 462. *Id.* at 16,470. Senator Williams, supporting the bill, described in detail the

abuses of institutionalization to which the measure was addressed.

Over the past few years, the horrifying conditions which exist in most of the public residential institutions for the mentally retarded and other developmentally disabled persons have provided shocking testimony to the inhuman way we care for such persons. The conditions at Willowbrook, at Partlow in Alabama, and at Rosewood in Maryland, and at many other institutions have shown beyond a shadow of a doubt that the treatment of these individuals is worse than [sic] all of us would like to admit.

Steps to scale down many of these large custodial institutions have resulted in not-so-large institutions, often with not much improved care and with little follow-up. This has been true at Willowbrook: in 1965 and again in 1972, broad criticism has been levied at this institution; all indications point toward little change, unless substantial legal and advocacy pressure is forthcoming. While much can be said about the lack of available funds to improve conditions at these institutions, at some point this country must draw the line. The abuses are too commonplace to point at a single institution, or a single abuse and say that it is an anomaly. Over the last 2 years the Committee on Labor and Public Welfare has taken testimony or received reports of: Inappropriate admissions because of lack of community services, inappropriate and inhuman experimentation with residents, sterilizations and other operations performed for convenience of treatment, starvation and malnutrition, abuse and physical punishment, inadequate food and living conditions, and death.

S. 462 provides a framework by which the constitutional rights of residents and other persons with developmental disabilities may be enforced.

Id. at 16,516-17. Senator Kennedy echoed these sentiments.

> Last year in testimony on this legislation, Geraldo Rivera showed the committee portions of his documentary on Willowbrook, and if anyone needed convincing of the need for the establishment of institutional standards, that film provided it. This legislation provides for the establishment of such standards.

Id. at 16,517. So, too, did Senator Cranston, *id.* at 16,-520 ("I believe one very clear basic goal has been enunciated in the legislation reported from committee. That is the need to move away from long-term institutionalization of individuals with developmental disabilities to the development of community-based programs utilizing all community resources related to treatment or habilitation of such individuals to provide comprehensive services in the home community."); Senator Schweiker, *id.* at 16,-521 ("The last 5 years have seen a dramatic increase in public awareness of the needs of institutionalized mentally retarded and developmentally disabled persons. This has been highlighted by scandals in many institutions, by court cases, and by the efforts of the communications media. Testimony before the committee demonstrated that standards in institutions for the developmentally disabled are urgently needed and that the Federal Government should play a major role in improving the care and services provided to developmentally disabled citizens."); and Senator Beall, *id.* at 16,522 ("In

addition, I would like to express my support of title II of this bill, which reflects the increasing concern of Congress and the public in general about persons who are institutionalized because they are developmentally disabled. Increased technological development, especially in regard to travel speeds, and the sociological stress that many of our citizens are experiencing, particularly in this time of economic strain and increased crime, evidence the sad fact that there will be an increased need for psychological care. Residential care outside the home is necessary in some instances, although I am glad to say that increased emphasis is being placed on similar community-based facilities rather than the larger State institutions. Title II assures those individuals who must be institutionalized of their civil and personal rights, and, at the same time, provides for the best possible care and services.")

The Senate substituted the text of S. 462 for the House bill, H. R. 4005, and passed it. *Id.* at 16,523. A conference was convened and as noted above, the Senate's expansive delineation of the standards for institutional and community care was dropped and a more general Bill of Rights (section 6010) was adopted. Nevertheless, the Congress was serious about the Bill of Rights. The Conference Report noted the difference between the Senate and House versions of the Act, and explained the resulting compromise:

> *Statement of Purpose*
>
> The Senate amendment, but not the House bill, states the purpose of this bill of rights to be establishing standards to assure the humane care, treatment, habilitation and protection of mentally retarded and other developmentally disabled individ-

uals who are served by residential and community facilities and agencies.

The conference substitute contains a compromise which enumerates Congressional findings respecting the rights of persons with developmental disabilities. These include findings that the developmentally disabled have a right to appropriate treatment, services and habilitation; that such treatment, services and habilitation should be designed to maximize the developmental potential of the person and be provided *in the setting that is least restrictive to his personal liberty;* that the Federal government and the States have an obligation to assure that public funds are not provided in programs which do not provide appropriate treatment, services and habilitation or do not meet minimum standards respecting diet, medical and dental services, use of restraints, visiting hours and compliance with fire and safety codes; and that programs for the developmentally disabled should meet appropriate standards including standards adjusted for the size of the institutions which are at least comparable to those promulgated under title 19 of the Social Security Act. (Emphasis added.)

H. R. Conf. Rep. No. 94-473, 41-42 (1975), [1975] U.S. Code Cong. & Ad. News 943, 961.

When the Conference Report was submitted to the Senate, the new version of Title II (the Bill of Rights) was specifically reprinted so as "to emphasize the importance of this title of the bill." 121 Cong. Rec. 29,819 (1975) (remarks of Sen. Stafford). Senators Javits, Schweiker, and Williams all called attention to the Bill of

Rights in applauding the compromise measure. *Id.* at 29,820-21.

Yet, While it disfavored institutionalization, the Developmentally Disabled Assistance and Bill of Rights Act did not prohibit all institutions. Congressman Carter, introducing H. R. 4005, stated "[t]he legislation also directs that States should devote attention to improving the facilities and surroundings of institutions where people have been appropriately institutionalized." *Id.* at 9976. Senator Stafford reported that "Title II was added to the bill to assist in the protection of the rights guaranteed under our Constitution for those individuals that will require institutionalization . . ." *Id.* at 16,516. And Senator Cranston observed that "in encouraging the movement to community-based programs, I recognize that the need for some long-term residential programs will remain. The bill specifically provides that where institutional programs are appropriate, adequate support should be planned for them so that necessary treatment and habilitation programs can be given residential patients to develop their full potential." *Id.* at 16,520. These same points were reflected in the Conference Report. Explaining the Bill of Rights provisions, the Report stated:

> These rights are generally included in the conference substitute in recognition by the conferees that the developmentally disabled, particularly those who have the misfortune to require institutionalization, have a right to receive appropriate treatment for the conditions for which they are institutionalized, and that this right should be protected and assured by the Congress and the courts.

H. R. Conf. Rep. No. 94-473, 42 (1975), [1975] U.S. Code Cong. & Ad. News 943, 961.

The Act does not, therefore, articulate a *per se* rule prohibiting institutions. That was not how the Congress understood the right to the least restrictive alternative. Rather, it seems that Congress believed that, for some patients, institutionalization might be "appropriate." In those individual cases, probably comparatively rare, adequate habilitation could not be accomplished in any setting less restrictive than an institution and the need for such habilitation could thereby justify institutionalization.

It is argued, however, that because the Act, until 1978, required states to spend a specific minimum amount for deinstitutionalization, the states were free to use institutions as much as they chose so long as they spent the specified amounts on alternative facilities. According to this thesis, states might retain full or nearly full institutionalization even for those patients for whom institutionalization was not "appropriate." We do not accept this contention. The spending requirement was clearly intended to encourage the development of alternative facilities. Congress rightly believed that the states were doing too little to develop alternatives to institutions. The minimum expenditure requirement must not be confused with a maximum duty on the States' parts; to do so would substantially undermine the rights articulated in section 6010 and the insistence on specific deinstitutionalization plans in section 6063.

We hold, therefore, that the Developmentally Disabled Assistance and Bill of Rights Act provides to mentally retarded persons the right to the least restrictive

environment. For some patients, to be sure, the Act contemplates that institutionalization might be appropriate once adequate habilitation and living conditions are established. The clear preference of the Act, however, is deinstitutionalization, and for the reasons set forth in Part V A(1), we have no doubt about Congressional power to impose the least restrictive alternative requirement upon the states for patients who do not require institutionalization for adequate habilitation.

B. *Section 504 of the Rehabilitation Act of 1973*

Appellees argue that section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794 (1976), also reflects Congressional desire to discourage the institutionalization of the mentally handicapped.[29]

While its language is somewhat opaque, appellees argue that the illuminating legislative history of section 504 supports the view that Congress sought in that section to combat, to the extent appropriate, the isolation of the handicapped from the community—an isolation which

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[29] Section 504 provides

> No otherwise qualified handicapped individual in the United States, . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

29 U.S.C. §794 (1976).

Section 504 is the final section of the Rehabilitation Act of 1973. Textually, section 504 parallels the language of section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d (1976), and of section 901 of Title IX of the Educational Amendments of 1972, 20 U.S.C. §1681 (1976). Its passage was the result of a long effort to obtain for the handicapped a civil rights act similar to section 601 and section 901.

it believed was ineluctably entailed by institutionalization.[30] Thus section 504, appellees argue, provides an alternative statutory basis for enforcing the right to a least restrictive environment or that the legislative history of section 504 offers powerful corroboration for the deinstitutionalist purposes of the Developmentally Disabled Assistance and Bill of Rights Act. However, because we have found clear expression of a least restrictive alternative requirement in the Developmentally Disabled Assistance and Bill of Rights Act, and ample confirmation of that expression in its legislative history, we find it unnecessary to consider these arguments. Once clear federal statute announces the governing rule, and one is enough. Thus we decline to consider section 504 issues on this appeal.

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[30] *See* 118 Cong. Rec. 525 (1972) (remarks of Sen. Humphrey) (anti-isolation purposes of proposed amendment to §601, predecessor to §504); H.R. 8395, 92d Cong., 2d Sess. (1972) (Rehabilitation Act of 1972, predecessor bill of Rehabilitation Act of 1973); 118 Cong. Rec. 32,280 (1972) (remarks of Sen. Cranston) (anti-discrimination and anti-isolation purposes of Act); *id.* at 32,310 (remarks of Sen. Humphrey) (same); *id.* at 35,163 (anti-discrimination provision accepted by House in conference); *id.* at 36,410 (remarks of Rep. Brademas) (opposing isolation of handicapped due to institutionalization); *id.* at 36,414 (remarks of Rep. Badillo) (same); *id.* at 37,203-04 (Rehabilitation Act of 1972 vetoed by Pres. Nixon). The bill was reintroduced as the Rehabilitation Act of 1973, S. 7. 93d Cong., 1st Sess. (1973), and section 504 was finally enacted as part of this Act, with its proponents again emphasizing anti-isolation principles. *See* 119 Cong. Rec. 5880 (1973) (remarks of Sen. Cranston); *id.* at 5887 (remarks of Sen. Javits); *id.* at 18,127 (remarks of Rep. Brademas); *id.* at 24,566 (remarks of Sen. Stafford).

VII. RELIEF

We have thus far concluded that the mentally retarded patients at Pennhurst have federal and state protected rights to habilitation in the least restrictive environment. Moreover, it goes almost without saying that Pennhurst, as it was constituted and operated at the time of the lawsuit, was in flagrant violation of those rights. The conditions at Pennhurst were unsanitary, programming was nonexistent, enforced idleness was substituted for meaningful habilitation, physical and chemical restraints were wantonly applied, and overcrowding and understaffing were the prevailing institutional norms. Yet, appellants contend that even if they were properly found liable under federal and state law, the trial court nevertheless erred in several respects in ordering the relief that it did. First, they argue, the court order violates the eleventh amendment insofar as its effectuation will require an allocation of funds from the state treasury. Second they urge, the relief should not have been classwide since events have disclosed a material rupture within the affected class. Third, appellants protest the appointment of a special master as beyond the scope of Rule 53 (b), Fed. R. Civ. P. 53 (b). Finally, they contend, several specific portions of the court order are legally unsupportable. These include: the requirement that patients and/or their next friend participate in the structuring of relief and review of the plan; the requirement that certain local rules on physical and chemical restraints be implemented; the requirement that a "friend-advocate" system be established; the requirement that alternate employment for each Pennhurst employee be found; and the requirement that Pennhurst be closed entirely and community living arrangements established in its place. While most of these ob-

jections are insubstantial, we do agree that the ordered relief is somewhat overbroad. Accordingly, the injunction will be modified in accordance with our discussion below.

A. *The Eleventh Amendment*

The Commonwealth defendants assail the decree as a violation of the eleventh amendment. They urge that although the decree is couched in terms of prospective injunctive relief, its effectuation will nevertheless require the expenditure of Commonwealth funds. This result, it is urged, is forbidden by *Edelman v. Jordan,* 415 U.S. 651 (1974). Yet *Edelman* specifically acknowledges the continued availability of prospective injunctive relief even though such relief realistically does impose financial burdens. 415 U.S. at 667-68. *See Fitzpatrick v. Bitzer,* 427 U.S. 445, 459-60 (Stevens, J., concurring). All of the relief ordered here is prospective. We have told the Commonwealth before that *Edelman* "quite explicitly left intact the authority of federal courts to enter prospective decrees having fiscal consequences to a state treasury as the necessary result of compliance." *Vecchione v. Wohlgemuth,* 558 F.2d 150, 158 (3d Cir.), *cert. denied,* 434 U.S. 943 (1977). We have not changed our minds on that question.

We note, in addition, that the Supreme Court has recently reaffirmed this position. In *Quern v. Jordan,* 440 U.S. 332 (1979), the Court held that it was not a violation of the eleventh amendment for a federal court to order state officials to send an explanatory notice to members of a class advising them that there are state administrative procedures available by which they may receive a determination of whether they are entitled to past

welfare benefits. The mere fact that such notices might eventually lead to an expenditure of funds by the state did not alter the fact that the relief was "properly viewed as ancillary to the prospective relief already ordered by the court." 440 U.S. at 349.

We therefore reject appellants' eleventh amendment objections.

B. *Classwide Relief*

On April 13, 1978, a motion to intervene in order to protest the possible closing of Pennhurst was filed on behalf of the Pennhurst Parents-Staff Association and six Pennhurst residents. That motion, which was made after the Commonwealth and Philadelphia defendants had filed their notices of appeal, was denied, and the appeal from that denial is considered separately at No. 78-1999. In their appeal in this case, the Commonwealth defendants rely on that motion to intervene as evidence that the interests of the plaintiffs were adverse to one another, and thus that the trial court erred, first in certifying the class and second, in granting classwide relief. We reject completely the first contention. The certification of the class for purposes of determining liability was entirely proper. Plainly, the violations of federal and state law which the trial court found and which we have affirmed, are violations affecting all of the plaintiffs, not simply those who wish a transfer from Pennhurst. At the liability stage, therefore, important questions of law were common to all members of the class. Thus, regardless of any subsequent disagreement among class members as to the appropriate relief, we can think of no persuasive reason to have fractionated the class at that early juncture. *See* Fed. R. Civ. P. 23(c)(4)(A) (permitting use of

class action device for purposes of particular issues within lawsuit). As Judge Frankel observed in the context of class actions brought under Rule 23(b)(3), Fed. R. Civ. P. 23(b)(3):

> In the cases to which I refer, assertedly under (b)(3)—i.e., having both common issues and issues affecting separately the individual members of the class—district judges have apparently thought that all members of the class would have to be brought before the court—for discovery as well as trial—before there could be any judgment affecting the class as a whole. Insofar as this premise lurks in the cited cases, it would appear to be unwarranted. Take, for example, the simple model of the case by an alleged class of securities purchasers charging fraudulent representations. There are, supposedly, common questions as to the nature of the alleged representations, falsity, and materiality. If some or all such questions are decided against the plaintiff class, the complaint will be dismissed and, always assuming adequate representation of the class, there will be a judgment binding the class without requiring any but the representative members to have been before the court.
>
> On the other hand, if the plaintiff class prevails on the common questions, it will then—but only then—become necessary to try to settle or otherwise dispose of individual questions like reliance, damages, or the like. If the common questions have been aptly defined, there should be no need at an earlier stage to have all the individual class members before the court for discovery or any other purpose.

Frankel, *Some Preliminary Observations Concerning Civil Rule 23*, 43 F.R.D. 39, 47 (1967) (footnote omitted). *See also Developments in the Law—Class Actions*, 89 Harv. L. Rev. 1318, 1491-92 (1976). It was not abuse of the trial court's discretion to certify the class for purposes of determining liability.[31]

The Commonwealth contends, however, that because some members of the plaintiff class are opposed to the closing of Pennhurst, the class should at least have been decertified for purposes of relief. Thus, it argues that classwide relief infringes on the dissenting members' rights. As we indicate in more detail below, the trial court did err in promulgating a blanket order closing Pennhurst without sufficiently canvassing the needs of individual patients. Accordingly, inasmuch as we modify the court order appealed from, our opinion takes account of the differences within the class concerning relief. Nevertheless, we do not think that the implementation of the relief, as modified by our opinion, requires the decertification of the class. Two procedural alternatives, short of decertification, are available to the trial court on remand in implementing individuated relief.

First, the court can create subclasses within the plaintiff class pursuant to Rule 23 (c) (4) (B). Through this process, individual patients who wish to remain at Pennhurst may be represented at the implementation hearings. We suggested this approach in *Samuel v. University of Pittsburgh*, 538 F.2d 991 (3d Cir. 1976) (Clark, J.). There, we reversed a trial court decision

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[31] *See Paton v. La Prade*, 524 F.2d 862, 875 (3d Cir. 1975); *Wetzel v. Liberty Mut. Ins. Co.*, 508 F.2d 239, 245 (3d Cir.), *cert. denied*, 421 U.S. 1011 (1975).

decertifying a class at the relief stage. We stated that "even if there were managerial difficulties [in litigating the appropriate relief], some investigation into the possible usefulness of subclasses as suggested by Rule 23 (c) (4) (B) should have been undertaken before decertification was ordered." 538 F.2d at 996. *See also Nix v. Grand Lodge of Int'l. Ass'n of Mach. & Aero. Workers,* 479 F.2d 382, 385 (5th Cir.), *cert. denied,* 414 U.S. 1024 (1973); *Developments in the Law—Class Actions,* 89 Harv. L. Rev. 1318, 1479-82 (1976).

Yet another means by which dissenting members may be represented at the relief stage is through intervention. *See id.* at 1482-85. We note in this connection that the trial court currently has under consideration a motion by the Pennhurst Parents-Staff Association—who purport to represent patients opposed to closing Pennhurst —to intervene at the relief stage.

Even should the trial court ultimately decline to pursue either of these two procedural alternatives to decertification, the interests of dissenting members will still be represented. As we suggested above, and as we will elaborate at greater length below, plaintiffs' right to habilitation in the least restrictive environment requires that they be given an individual opportunity to participate in the process by which their habilitation is chosen. Thus, whether they are represented as a group, through such procedural safeguards as subclasses or intervention, or whether they participate as individuals, class members who wish continued habilitation at Pennhurst will have a chance to state their position.

C. *The Use of a Master*

The court found that implementation of its order would be impossible without the assistance of a Special Master "with the power and duty to plan, organize, direct, supervise and monitor the implementation of this and any further Orders . . ." 446 F. Supp. at 1326. It directed the Commonwealth and County defendants to provide the Master with access to premises, records, documents, and residents, and to cooperate with him to the extent necessary to execute such orders. The Master was directed to prepare and present to the court for its approval various plans for the transfer of Pennhurst residents to CLAs and for the provision of services to the class members "in the least separate, most integrated, least restrictive community setting," taking into account available resources. *Id.* at 1326-27. The order also directed that the Master prepare a plan for the interim operation of Pennhurst pending its replacement by other living arrangements and services.

The appellants contend that appointment of a master was improper under Rule 53(b), Fed. R. Civ. P. 53(b). We disagree. It is abundantly clear that providing the 1200 Pennhurst residents with a right to habilitation in the least restrictive environment will be a complex and lengthy process, probably involving monitoring, dispute resolution, and development of detailed enforcement mechanisms. Were we to preclude the trial court from resorting to a master, we would help make self-fulfilling the frequently made prophecy that courts are institutionally incapable of remedying wholesale violations of legally protected rights. Masters have been used in a wide variety of remedial contexts. These include

cases involving handicapped children,[32] as well as cases remedying various other statutory or constitutional violations.[33] Masters are peculiarly appropriate in the implementation of complex equitable decrees which require ongoing judicial supervision.[34]

Moreover, by use of a master, the judge can minimize his personal participation in the details of implementation without sacrificing direct control or efficacy.[35]

While they acknowledge that courts have frequently relied upon special masters, appellants nonetheless insist that the master appointed by the trial court in this case will have excessive powers. "The proper role of a master

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[32] *See e.g., Mills v. Board of Educ.*, 348 F. Supp. 866 (D.D.C. 1972); *Pennsylvania Ass'n for Retarded Children (PARC) v. Pennsylvania*, 334 F. Supp. 1257 (E.D. Pa. 1971); 343 F. Supp. 279 (E.D. Pa. 1972).

[33] *See, e.g., Chicago Hous. Auth. v. Austin*, 511 F.2d 82 (7th Cir. 1975) (overseeing implementation in public housing discrimination case); *Gautreux v. Chicago Hous. Auth.*, 384 F. Supp. 37 (N.D. Ill. 1974) (same); *Hart v. Community Sch. Bd.*, 383 F. Supp. 699 (E.D.N.Y. 1974) *aff's* 512 F.2d 37 (2d Cir. 1975) (coordinating development of desegregation plan in housing and school discrimination case); *Moore v. Leflore County Bd. of Election Comm'rs*, 361 F. Supp. 603 (N.D. Miss. 1972) (formulating reapportionment plan); *Gates v. Collier*, 349 F. Supp. 881 (N.D. Miss. 1972) (implementing prison reform), *aff'd*, 501 F.2d 1291 (5th Cir. 1974); *Knight v. Board of Educ.*, 48 F.R.D. 115 (E.D.N.Y. 1969) (conducting due process grievance hearings in schools).

[34] *See generally Note, Implementation Problems in Institutional Reform Litigation*, 91 Harv. L. Rev. 428 (1977); Note, *Monitors: A New Equitable Remedy?*, 70 Yale L.J. 103 (1960).

[35] Note, *Implementation Problems in Institutional Reform Litigation*, 91 Harv. L. Rev. 428, 451 (1977); Kaufman, *Mastes in the Federal Courts:* Rule 53, 58 Colum. L. Rev. 452, 469 (1958).

in federal litigation," appellants urge, "is narrowly circumscribed." Brief for Commonwealth Appellant at 49. Specifically, it is urged, a master may only find facts. Since the lower court has already found the facts, any use of a master for implementation purposes intrudes excessively into the proper domain of local autonomy. *Id.* at 51-52.

This argument is unpersuasive. First, the Commonwealth is simply incorrect in asserting that the scope of a master's duties is narrow. As one commentator has properly noted, "[m]asters may be delegated the authority to issue subpoenas, hear grievances, take sworn testimony, and make formal or binding recommendations, including contempt findings, to the court." Note, *Implementation Problems in Institutional Reform Litigation,* 91 Harv. L. Rev. 428, 451 (1977). In employment discrimination cases, for example, court-appointed administrators, who have the same powers as masters, have made frequent and successful use of rather wide-ranging powers. *See* Harris, *The Title VII Administrator: A Case Study in Judicial Flexibility,* 60 Cornell L. Rev. 53 (1974). Authorized to take all action necessary to implement the decree and to remedy breaches of compliance, these administrators have performed negotiating and investigatory functions, and have issued recommendations for future implementation. *Id.* at 55, 64. *See* Note, *Implementation Problems in Institutional Reform Litigation,* 91 Harv. L. Rev. 428, 452 (1977).

In this case, moreover, the court's resort to use of a master is particularly appropriate. After the decision on liability was announced, the appellants were afforded an opportunity to devise and present their own remedies for conditions at Pennhurst. They failed to do so. At that

point, having received insufficient assistance from the officials directly involved, the court was faced with the choice of massive personal participation in devising a complex scheme for remedying the violations that were found, or of proceeding with the assistance of a master, whose functions would be supplementary to and supervisory over those of the Commonwealth and County defendants. We hold that the trial court chose correctly in ordering the appointment of a master. We are confident that the court will exercise appropriate supervision over the operations of the Master in order to minimize the expenditure of funds in the administration of his responsibilities and the manner in which he discharges his responsibilities under the decree; in particular, the manner in which individualized habilitation programs are developed for each class member. As we understand the role of the Master under the decree, he is to supervise all implementation efforts with the aid and assistance of all parties to the lawsuit. The defendants will thus have an opportunity to participate in the structuring of relief. Moreover, their underlying obligation to provide habilitation in the least restrictive environment is derived, in part, from a state statute and federal statutes under which Pennsylvania has received federal funds. These duties were known and consented to. These considerations, in our view, vitiate whatever complaint the Commonwealth might otherwise have that the court order somehow violates whatever principles of federalism are relevant. Brief for Appellant at 59-62.

D. *Specific Objections to the Court Order*

Appellants also contest certain specific portions of the court's decree. They object to paragraph 2, 446 F.

Supp. at 1326, which entitles members of the class and their next friend to participate in the development and review of the plan. They protest that paragraph 13, *id.* at 1328, requiring that certain local rules on physical and chemical restraints be implemented, is inapplicable since (1) the rules were not in effect long enough to permit a finding that they were violated, and (2) the rules are not statutorily compelled. In addition, appellants contend that paragraph 6, *id.* at 1326-27, imposes on the state duties which have no legal source; these duties include the establishment of a friend-advocate system and the provision of alternative employment for each Pennhurst employee. Finally, appellants argue that the trial court should not have ordered that Pennhurst be entirely closed, particularly in view of the apparent desire of certain members of the class to remain at the institution once it is improved.

Criteria for evaluating the trial court's exercise of discretion in effecting a remedy are set forth in *Milliken v. Bradley,* 433 U.S. 267, 279-288 (1977) *(Milliken II)*. There, the Court held that if an alleged injury is constitutionally (or presumably statutorily) cognizable, "the remedy does not 'exceed' the violation if the remedy is tailored to cure the ' "condition that offends the Constitution." ' " *Id.* at 282 (quoting *Milliken v. Bradley,* 418 U.S. 717, 738 (1974) *(Milliken I))* (emphasis added by the *Milliken II* Court). In *Milliken II,* the Court affirmed a district court decision to order certain remedial reading, testing, and counseling services. These remedies, the Court concluded, were found by the trial court to be necessary to "cure" the "condition" of *de jure* segregation in Detroit. *Id.* at 288. The Supreme Court could find no reason to believe that the district court had abused

its "broad and flexible equity powers" in reaching this determination. *Id.*

Under these liberal standards, we have no trouble upholding paragraphs 2 and 13 of the court order. In this case, the "condition" to be "cured" is the failure to provide the retarded with adequate habilitation in the least restrictive environment. Both paragraphs 2 and 13 are directly addressed to remedying this condition. Parental and patient participation in the design of alternative facilities is well-suited to redressing the violations of the rights of the retarded. So, too, are the restrictions imposed by the court against physical and chemical restraints.

In addition, we affirm that portion of paragraph 6 which establishes a friend-advocate system to monitor the continued availability of community services to the retarded. Not only will such a system help to effectuate the rights of the retarded but, by providing ongoing supervision of implementation efforts, it will reduce the need for judicial oversight.

The court's decree should be modified in two respects. First, we cannot agree with that portion of paragraph 6 requiring that alternative employment be provided to all Pennhurst employees. Even under the liberal standards of *Milliken II*, we do not see how this mandate is reasonably related to facilitating the right of the retarded to habilitation in the least restrictive environment. This section of the court's order must therefore be set aside.

Second, we cannot agree with the trial court that Pennhurst must be entirely closed. In so ruling, the

court first noted that Pennhurst was not providing adequate habilitation at the time of the litigation. 446 F. Supp. at 1318. With that conclusion we obviously agree. But the court also held that Pennhurst could *never* provide adequate habilitation because of its very status as a large institution.

> [O]n the basis of this record we find that minimally adequate habilitation cannot be provided in an institution such as Pennhurst. As the Court has heretofore found, Pennhurst does not provide an atmosphere conducive to normalization which is so vital to the retarded if they are to be given the opportunity to acquire, maintain and improve their life skills. Pennhurst provides confinement and isolation, the antithesis of habilitation. We found that Pennhurst has produced regression and in many instances has destroyed life skills possessed by its retarded residents at the time of their admission. We are inclined to agree with the following comments of Mason & Menolascino, . . . (footnotes omitted):
>
> Although *Wyatt* and *Welsh* are significant in their recognition of the principles of normalization and the developmental model for the factual foundation of their formulation of the constitutional right to habilitation, their approach can be considered only the rudimentary beginning. The logic of normalization and the developmental model which *Wyatt* and *Welsh* recognized suggests full implementation of habilitation can only be achieved in a non-institutional setting. Institutions, by their very structure—a closed and segregated society founded on obsolete custodial models—can rarely normalize and habilitate the mentally retarded citizen to the extent of com-

> munity programs created and modeled upon the normalization and development approach components of habilitation. Neither *Wyatt* nor *Welsh* fully implemented the right to habilitation in that they failed to challenge the very existence of the institution. Consequently, the two institutional characteristics most antithetical to the application of the normalization principle remain intact: segregation from the community and the total sheltering of retarded citizens in all spheres of their lives.

Id. (footnote omitted) (quoting Mason & Menolascino, *The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal and Scientific Interface,* 10 Creighton L. Rev. 124, 156-57 (1976)). The court was thus apparently persuaded to the view, shared by many practitioners, that institutionalization of any sort is a deterrent to adequate habilitation.[36]

It is probably true, as the trial court found, that in general institutions are less effective than community living arrangements in facilitating the right to habilitation in the least restrictive setting. There is ample testimony on the record indicating the shortcomings of institutions as places for habilitation. *See, e.g.,* Record, vol. 1, at 96 (testimony of Dr. Roos); Record, vol. 4, at 73 (testimony of Mr. Lancaster-Gaye); Record, vol. 2, at 96 (testimony of Dr. Clements). Moreover, institutions would generally appear not to be the least restrictive environment in which to provide habilitation. *See* Record vol. 4, at 79 (testimony of Mr. Lancaster-Gaye); Record,

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[36] *See, e.g.,* Burt, *Beyond the Right to Habilitation,* in *The Mentally Retarded Citizen and the Law,* 418-36 (President's Committee on Mental Retardation, 1976).

vol. 2, at 85 (testimony of Dr. Clements); Record, vol. 1, at 179 (testimony of Dr. Roos). Thus we cannot find clearly erroneous the trial court's determination that, for the retarded class members as a whole, Pennhurst cannot be an appropriate setting in which to provide habilitation.

But in making this wholesale judgment, the trial court did not adequately canvass the discrete needs of *individual* patients. For some patients a transfer from Pennhurst might be too unsettling a move. Longterm patients, for example, may have suffered such degeneration in the minimum skills needed for community living that habilitation outside an institution is a practical impossibility. Indeed, the Pennhurst Parents-Staff Association, which has participated as an amicus in this appeal, contends that this is true for many patients. Moreover, there seems to be some support among practitioners for this view as well.[37] We need not decide that issue here. All that we need recognize is that there may be some individual patients who, because of advanced age, profound degree of retardation, special needs or for some other reason, will not be able to adjust to life outside of an institution and thus will be harmed by such a change. The case must therefore be remanded for individual determinations by the court, or by the Special Master, as to the appropriateness of an improved Pennhurst for each such patient.

We base our ruling on the *nature* of the rights being enforced in this case. The framers of 42 U.S.C.

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[37] *See e.g.*, Clements, *Reaction Comment*, in *The Mentally Retarded Citizen and the Law*, 437 (President's Committee on Mental Retardation, 1976); M. Rosen, G. Clark, & M. Kivitz, *Habilitation of the Handicapped*, 101-11 (1977).

§§6001-6081, as we have noted, did not anticipate a shutdown of all institutions when they endorsed a right to habilitation in the least restrictive environment. Rather, they recognized that for some patients institutions, once improved, might be appropriate. Similarly, we do not think that the Pennsylvania legislature, in providing a right to treatment in the Mental Health and Mental Retardation Act of 1966, intended to foreclose all institutionalization. In section 102 of that Act, for example, the legislature expressly included "institution[s]" within the category of "facilities" for which the Department of Public Welfare was responsible. Pa. Stat. Ann. tit. 50, §4102. Thus, we see in the MH/MR Act of 1966 exactly the intent ascribed to it by Senator Pechan when he spoke in support of the measure.

> The object of the legislation is to make it possible for every mentally disabled person to receive the kind of treatment he needs, when and where he needs it.

1966 Pa. Legis. J., 3d Spec. Sess., No. 33, 76 (Sept. 27, 1966). The state statute, like the federal statute, was focused on *individual* needs. Since the statutory rights to treatment, state and federal, vindicate the individual patient's fundamental interest in personal liberty, it is only fitting that the Commonwealth be required to undertake a case-by-case investigation into how each person's rights may best be facilitated.

The right to the least restrictive environment also supports an individualized approach. Insofar as the right derives from sections 6001-6081, it is plain that no *per se* rule against institutions was contemplated. Moreover, although we do not predicate our holding on a constitu-

tional right to treatment in the least restrictive setting, we note that such a constitutional right would protect the liberty interest of *individuals.* It would be anomalous to recognize the right to the least restrictive environment but never inquire whether a given individual can adjust to the environment to which he has been consigned. Thus to the extent that the district court predicated its blanket prohibition against institutionalizaion in Pennhurst on the fourteenth amendment, we disagree. Whatever the Constitution *requires* by way of least restrictive alternatives, it does not *preclude* resort to institutionalization of patients for whom life in an institution has been found to be the least restrictive environment in which they can survive.

Of course, deinstitutionalization is the favored approach to habilitation. The federal statutory material makes that clear and we acknowledge that constitutional law developments incline in that direction as well.[38]

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[38] *See, e.g., Parham v. J.L.*, — U.S. —, 99 S.Ct. 2493, 2502-03 (1979); *Secretary of Public Welfare of Pennsylvania v. Institutionalized Juveniles*, 47 U.S.L.W. 4754, 4756 (U.S. June 20, 1979); *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975); *Welsch v. Likins*, 550 F.2d 1122, 1125-26 (8th Cir. 1977); *affirming in relevant part, vacating and remanding in part*, 373 F. Supp. 487 (D. Minn. 1974); *Lake v. Cameron*, 364 F.2d 657, 663 (D.C. Cir. 1966) (en banc); *Evans v. Washington*, 459 F.Supp. 483, 484 (D.D.C. 1978) (by consent decree); *Eubanks v. Clarke*, 434 F. Supp. 1022, 1027-28 (E.D. Pa. 1977); *Gary W. v. State of Louisiana*, 437 F. Supp. 1209 (E.D. La. 1976); *Suzuki v. Quisenberry*, 411 F. Supp. 1113, 1132-33 (D. Hawaii 1976); *Lynch v. Baxley*, 386 F. Supp. 378, 392 (M.D. Ala. 1974) (three judge court); *Davis v. Watkins*, 384 F. Supp. 1196, 1203, 1206 (N.D. Ohio 1974) (by stipulation); *Saville v. Treadway*, 404 F. Supp. 430, 433 (M.D. Tenn. 1974) (by stipulation); *Lessard v. Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972),

Thus, on remand, the court or the Master should engage a presumption in favor of placing individuals in CLAs. But the special needs and desires of individual patients must not be neglected in the process.

Finally, consideration must be given to the order directed to the future activity of the Base Service Units. That order essentially imposes an absolute ban on admissions to Pennhurst, paragraphs 9, 10, 446 F. Supp. at 1327, and requires that the defendants provide CLAs for all persons on the Pennhurst waiting list, *id.* at 1326, paragraph 1.

As we have noted with respect to current residents of Pennhurst, the court or the Master should engage in a presumption that individuals should be placed in CLAs. This presumption is equally important, if not more so, with respect to applicants for future admission. However, we have recognized that although institutionalization is strongly disfavored, it is not foreclosed completely by the governing federal and state statutes. It is conceivable that in processing a given future application, a Base Service Unit will find that no available CLA is suitable for the individual, life in the community is not possible, and no other alternative institution in the relevant geographic area is available. Modification of the decree to permit admission to Pennhurst of such an indi-

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vacated and remanded for a more specific order, 414 U.S. 473, *order on remand,* 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded on other grounds,* 421 U.S. 957 (1975), *order reinstated on remand,* 413 F. Supp. 1318 (E.D. Wis. 1976); *Wyatt v. Stickney,* 344 F. Supp. 373 (M.D. Ala. 1972); 344 F. Supp. 387 (M.D. Ala. 1972), *enforcing* 325 F. Supp. 781 (M.D. Ala. 1971), *affirmed in relevant part, remanded in part, and decision reserved in part, Wyatt v. Aderholt,* 503 F.2d 1305 (5th Cir. 1974).

vidual while it remains open, but under court supervision as in the case of present residents, seems appropriate. This would provide for the interim accommodation of such persons while, as the decree contemplates, and the Commonwealth intends, Pennhurst is being phased out. We emphasize again, however, that any determination with respect to future applicants must always be made with the least restrictive alternative in mind and that the modification is appropriate only because an extreme situation calling for institutionalization might arise. The precise mechansim for court supervision of the Base Service Units in this regard we leave to the district court.

Naturally, nothing we have said here should be understood to disapprove the interim measures ordered by the trial court for the improvement of Pennhurst. Quite the reverse: state and federal laws plainly require that if Pennhurst is to remain open for at least some patients, it must be dramatically improved so as to provide adequate habilitation. Neither should our willingness to permit retention of Pennhurst as an institution available for those who cannot be treated in any less restrictive environment be construed as an invitation to the appellants to desist from opening up alternative community facilities. As we have said, institutionalization is a disfavored approach to habilitation. Only where the court or the Master finds that an improved Pennhurst is the only appropriate place for individual patients should it be used. For all other patients, CLAs must be provided.[39] We

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[39] We note, in this connection, that the development of suitable CLAs will impose little, if any, financial burden on the State and Counties. As we indicated in Part III, the trial court made a finding, unchallenged on appeal, that per patient cost in CLAs is less than at Pennhurst. *See* 446 F. Supp. at 1312.

caution both the trial court and the Master that before ordering transfers to CLAs they must have assurances that the sanitary, staffings, and program deficiencies which were found at Pennhurst are not duplicated on a smaller scale in the CLAs. If staffing and programs are inadequate at the CLAs, then the goals of deinstitutionalization will not be met. Mere changes in the size of buildings and their location are not enough to meet the statutory requirements.

There are six other appeals pending in this court from orders entered subsequent to the March 17, 1978 order with which this opinion deals. By agreement of the parties, briefing has been postponed in these appeals pending disposition of this appeal. On remand, the district court should be free, despite the pendency of the appeals, to consider modification of the orders with which these appeals are concerned, in the light of the modification of the March 17, 1978 order that we have directed. Because the district court is free to consider modification of the orders subsequent to March 17, 1978, the motions for stays of those orders are denied without prejudice.

VIII. CONCLUSION

With the exception of the order to find alternative employment for all Pennhurst employees, the order directing the eventual closing of Pennhurst, and the order banning all future admissions to Pennhurst, the judgment of the trial court will be affirmed in all respects. To facilitate the inquiry into the appropriate setting for each patient's habilitation, the court may if it chooses, permit particular organizations to intervene at the relief stage or create subclasses. Alternatively, it may allow

the inquiry to proceed on a case-by-case basis. No matter how it is accomplished, however, an assessment of each class member's needs must be carried out. The case will therefore be remanded for further proceedings not inconsistent with this opinion. All parties shall bear their own costs.

SEITZ, *Chief Judge,* with whom Judges ALDISERT and HUNTER join, dissenting.

This case poses what is for the judiciary a singularly difficult and sensitive problem. At a federal judicial level, we are asked to interpret relatively new and innovative legislation and to embark upon uncharted constitutional waters. At a factual level, the record presents a mass of social science and medical data from which judges are asked to fashion legal rules.

Initially, I have no trouble agreeing with the majority that the conditions at Pennhurst revealed in this record fall below a statutory or constitutional threshold of decency so as to merit judicial intervention. The district court adequately documented the deplorable conditions at Pennhurst. *See* 446 F. Supp. at 1302-11. Understaffing, filth, violence, enforced inactivity, and other horrors make Pennhurst, in the opinion of one well-traveled expert, one of the worst institutions of its kind in the world. Under these circumstances the federal courts have a right and a duty to intervene and to secure for Pennhurst's residents, at the very least, adequate living conditions. *Cf. Norris v. Frame,* 585 F.2d 1183 (3d Cir. 1978) (scrutiny of pre-trial detainee's conditions of confinement). I thus have no hesitation in agreeing that

the federal judiciary should take the necessary steps to eliminate those conditions at Pennhurst.

Pennhurst as it exists today, however, must not obscure what is an entirely severable legal issue. That issue is the legality of institutionalization of the mentally retarded. The inquiry is not whether institutionalization is outmoded, undesirable, or unjustifiably expensive. Rather, the question is, assuming a Pennhurst without the deplorable living conditions here, may a federal court step in and say institutionalization is illegal, and if it can, what standard will the court employ in determining that illegality. It is on this issue that I part company with the majority.

The district court held that no matter how much one might change Pennhurst, it would never be legal to place a person in such a large institution. Although the majority rejects that theory, its position is that even if all the deplorable living conditions at Pennhurst are eliminated, it still is impermissible to place persons there if a large institution is not the least restrictive environment for that individual.

Such a rule goes far beyond the proposition that federal courts should require the state to eliminate the deplorable conditions at Pennhurst. The effect of the rule is to require the state to create new facilities regardless of the feasibility or practicality of such a course of action. Moreover, because persons develop over time, the federal courts will become embroiled in almost continual supervision to ensure that each individual at any particular moment is in the least restrictive environment.

Although I believe improvement of Pennhurst to be mandatory, I do not believe a federal court may dictate

to the state the type of treatment that best suits every individual. In my view, as long as the state runs all of its facilities free of the types of conditions that exist at Pennhurst today, then the state must be given latitude to choose in which of the facilities it will place a given individual. A federal court should remove a person from an institution or forbid a particular mode of treatment only in very limited circumstances. Because I can find no basis for the rule announced by the majority in statute or Constitution, I dissent from that portion of its opinion mandating a general right to individualized treatment in the least restrictive environment.

I. STATUTORY BASIS

A. Developmentally Disabled Assistance and Bill of Rights Act

I will assume that the majority is correct in asserting, first, that patients at Pennhurst have a right to treatment under the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§6000-6081 (the Act); and, second, that patients have an implied cause of action under the Act to enforce that right. These two conclusions, however, bring one no closer to an answer in this case, for it means little to say that a person has a "right" without defining it in a particular context. In this case, one must ask exactly what are the contours and substances of the right to treatment.

The starting point for an answer to this question is the nature and history of the implied cause of action. In England as early as the thirteenth century, the king's court fashioned private remedies by looking to duties imposed on the defendant by royal enactments. *See generally* J. Mashaw & R. Merrill, Introduction to the

American Public Law System 969-71 (1975); *Katz, The Jurisprudence of Remedies: Constitutional Legality and the Law of Torts in Bell v. Hood,* 117 U. Pa. L. Rev. 1 (1968). The essence of the implied cause of action is that the defendant breaches a duty imposed on him by a statute, and the breach in some way harms the plaintiff, who then may supplement the statutory scheme through a private suit. *See J. I. Case Co. v. Borak,* 377 U.S. 426 (1964). One cannot divorce the implied cause of action from a duty imposed on the defendant by the statute in question. Unless the defendant's activity violated the statute, there is nothing a court can properly redress.

Applying this precept to the case at hand, the question is whether the Act imposes a duty on the defendants to provide the least restrictive treatment possible to the plaintiffs. Unless it does, the Act cannot be a proper basis for the majority's holding. I agree with the majority that the legislative history indicates a preference for least restrictive treatment, but a preference cannot be elevated into a mandatory duty without explicit statutory authority.

The Act nowhere places such a duty of least restrictive treatment on those states accepting federal funding. The Act is extremely explicit as to the duties of those states that receive such funds. The heart of the state's duty under the Act is section 6063. Before the state can receive funds, it must submit a plan to the Secretary of Health, Education, and Welfare (HEW) for approval. Prior to the 1978 amendments, section 6063(b)(20) required that the state's submission to HEW contain:

> a plan designed (A) to eliminate inappropriate placement in institutions of persons with develop-

> mental disabilities, and (B) to improve the quality of care and the state of surroundings of persons for whom institutional care is appropriate.[1]

Moreover, the state must maintain individual habilitation plans and an advocacy system to ensure that the general plan approved by HEW is properly implemented. See 42 U.S.C. §§6011-6012. *Cf. id.* §§6007, 6067 (establishing state and national planning and advisory commissions).

The requirement in section 6063(b)(20), however, in no way imposes an absolute duty on the state to provide the least restrictive treatment. For example, the regulation dealing with this portion of a state's plan provides:

> The State plan shall support the establishment of community programs as alternatives to institutionalization and support such programs designed to provide services for the care and habilitation of persons with developmental disabilities, and which utilize, to the maximum extent feasible, the resources and personnel in related community programs to assure full coordination with such programs and to assure the provision of appropriate supplemental health, educational, or social services for persons with developmental disabilities.

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[1] This specific requirement was eliminated in 1978. The new provision still requires, however, that the plan deal with non-institutional treatment, albeit in a more general way. *See, e.g.*, 42 U.S.C.A. §6063(b)(5)(B)-(C) (1979 cumm. supp.). *Cf. id.* §6063(b)(7)(B) (state plan must deal with right of employees displaced because of relocation of patients in community living arrangements).

45 C.F.R. §1386.43 (1978). I fail to see how a duty to "support" "feasible" non-institutional care can be elevated to an absolute duty to provide the least restrictive treatment for every individual regardless of cost or available resources.

The Act elsewhere demonstrates that the state's limited resources may qualify its duty to provide alternate habilitation. For example, the state has primary control over where the funds are to be allocated. *See* 42 U.S.C. §6003. Indeed, the House Report on the 1975 version of the Act stated:

> Since the Committee is well aware that current theory with regard to the treatment and support of the developmentally disabled emphasizes that this treatment should be conducted in the individual's community without unnecessarily institutionalizing him, the Committee has chosen to include a specific requirement that state programs plan for as much deinstitutionalization as is feasible, and earmark monies for this purpose. Knowing that this may require some increase in expenditures, the Committee has also increased the authorizations of appropriations.
>
> It is anticipated that these requirements will prompt some movement of patients from State institutions back into their communities. It is hoped that corresponding amounts of State and other funds currently being spent on institutional care will be rebudgeted for community care, an obvious rebudgeting that has not always occurred in conjunction with deinstitutionalization efforts.

House Rep. No. 94-58, 94th Cong., 1st Sess. 10, *reprinted in* 2 U.S. Code Cong. & Admin. News 919, 928 (1975).

This passage illustrates that Congress intended the Act as no more than an incentive to deinstitutionalization, not an imposition of a mandatory requirement regardless of fiscal concerns.

Thus the language and structure of the Act, the relevant regulations, and the legislative history all indicate that the states may consider their own resources in providing less restrictive treatment. The duty of the states under the Act is to provide alternative individual habilitation to the extent feasible, which includes a wide variety of fiscal concerns. Yet the import of the approach taken by the majority is exactly the opposite: it imposes a duty to provide less restrictive treatment, regardless of cost or available funds. This is an approach entirely inconsistent with the nature of an implied cause of action, which must rest on the breach of a statutory duty. In effect, the majority transforms the duty of providing *feasible* alternative treatment into an entirely different substantive obligation that has absolutely no basis in the statutory scheme. It is improper to say an implied statutory cause of action exists and then impose new substantive duties nowhere present in the statute in question.

The majority places great emphasis on section 6010, the bill of rights section. The broad rights declared in section 6010 can be given concrete meaning, however, only by reference to the other provisions in the Act. I do not believe, especially with a funding statute such as the one here, that general findings and declarations should be used as a charter for the creation of absolute obligations where Congress felt the states should be free to choose on their own as to the proper allocation of funds. *Cf. Beal v. Doe,* 432 U.S. 438 (1977) (Title XIX gives states

latitude as to whether to spend federal funds on abortion). In sum, where Congress establishes a funding scheme designed to encourage a course of conduct, that is no license to federal courts to make that conduct mandatory.

None of this is meant to denigrate the purpose of section 6010. The time has passed when retarded persons can be considered citizens without any rights whatsoever. Those rights conferred by this Act are important and a significant step on the road on which our nation has a far way to go. Yet the judiciary should not permit such feelings to exceed the obligations imposed on states by the Act. Because the Act nowhere imposes an absolute duty on funded states to provide the least restrictive treatment regardless of cost or feasibility, I would hold that the Act does not support those portions of the district court's order that create such an obligation.

B. *Rehabilitation Act of 1973*

The district court held that continued confinement at Pennhurst, which receives federal funds under Title XIX of the Social Security Act, 42 U.S.C. §1396 *et seq*, violated section 504 of the Rehabilitation Act of 1973.[2] That provision, as amended in 1978, states in relevant part:

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[2] The arguments treated in this section are those of the plaintiffs, not the district court. That court concluded that "[i]n enacting Section 504 . . . Congress has in effect codified the constitutional right to equal protection." 446 F. Supp. at 1323. Because of its earlier conclusion that confinement at Pennhurst violated equal protection, *see* 446 F. Supp. at 1321-22, the district court felt that section 504 also had been violated. The district court's analysis of the section 504 claim accordingly is subsumed in my consideration of plaintiffs' equal protection claim. *See Part* II.B, *infra*.

> No otherwise qualified handicapped individual in the United States . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . .

29 U.S.C. §794, as amended, Pub. L. 95-602, §122(d)(2), 92 Stat. 2987 (1978).

The issue is whether section 504 mandates positive action by the state to create new, less restrictive habilitation facilities. On its face, the section merely says that states may not discriminate as to existing facilities; it does not require that the states take affirmative action. Thus in *Southeastern Community College v. Davis,* 99 S. Ct. 2361 (1979), the Supreme Court noted that section 504 did not require the state to create new facilities suitable for training nurses with hearing disabilities. After a thorough examination of the statutory structure and implementing regulations, the Court stated:

> If these regulations were to require substantial adjustments in existing programs beyond those necessary to eliminate discrimination against otherwise qualified individuals, they would do more than clarify the meaning of §504. Instead, they would constitute an unauthorized extension of the obligations imposed by that statute.
>
> . . . Section 504 does not refer at all to affirmative action, and except as it applies to federal employers it does not provide for implementation by administrative action. A comparison of these provisions demonstrates that Congress understood accom-

> modation of the needs of handicapped individuals may require affirmative action and knew how to provide for it in those instances where it wished to do so.

Id. at 2369 (footnote omitted).

The conclusion that section 504 imposes no such obligation in this case is supported by the legislative history. Most of the controversy surrounding the Rehabilitation Act concerned provisions other than section 504. As a result, legislative remarks about the purpose of that section are scarce and tend to restate the obvious. The provision's major thrust clearly is directed toward ensuring the handicapped equal access to federally-funded programs. *See, e.g.*, 118 Cong. Rec. 32,310 (Sept. 26, 1972) (remarks of Senator Humphrey); id. at 32,294 (Sept. 26, 1972) (remarks of Senator Cranston); Sen. Rep. No. 93-318, 93d Cong., 1st Sess., *reprinted in* 2 U.S. Code Cong. & Admin. News 2076, 2123, 2143 (1973).

Moreover, the structure and thrust of the Rehabilitation Acts of 1972 and 1973, of which section 504 was only one small part, undercuts plaintiffs' contention. The Acts essentially are funding statutes. They represent comprehensive attempts to deal with the plight of the handicapped, especially the most severely handicapped, *see* 29 U.S.C. §701, through a system of federal grants to states for the development of the enumerated programs. *See id.* §§720, 721, 762. One of the clear purposes of these grants was to offer states financial incentives to deinstitutionalize the mentally retarded. *See, e.g.*, 118 Cong. Rec. 32,305 (Sept. 26, 1972) (remarks of Senator Javits); *id.* at 36,414 (Oct. 14, 1972) (remarks of Congressman Badillo).

Given the emphasis in the Rehabilitation Act of 1972 and 1973 on encouraging the states to deinstitutionalize, I do not believe that there should be read into section 504, included in both those acts, a legislative mandate for deinstitutionalization. The carefully tailored system of programs and grants in the legislation as a whole belies any congressional intention to impose an absolute duty to provide the least restrictive treatment.

Plaintiffs offer two less expansive arguments in support of the district court's holding that section 504 mandates Pennhurst's closing. First, they argue that section 504 requires the termination of a federal program designed exclusively for the handicapped if that program prevents its beneficiaries from participating in *other* federal programs. This is quite novel. No court that has granted relief under section 504 has even implied that such an interpretation is possible. *See, e.g., Leary v. Crapsey,* 566 F.2d 863 (2d Cir. 1977); *United Handicapped Federation v. Andre,* 558 F.2d 413 (8th Cir. 1977); *Lloyd v. Regional Transportation Authority,* 548 F.2d 1277 (7th Cir. 1977). Moreover, I believe that plaintiffs' argument cannot be justified on this record.

Plaintiffs allude throughout their briefs to a variety of federally-funded programs for the handicapped that are unavailable to Pennhurst's residents. The district court heard 32 days of testimony and argument in this case. The parties took 27 depositions. The exhibits included 108 photographs, a three-hour film, and 288 documents. An examination of this massive record does not reveal, however, a single federally-funded program from which Pennhurst residents have been excluded. Indeed, the United States, intervening on behalf of plaintiffs, con-

cedes that the record fails to demonstrate that any programs using such funds were available to anyone in the five-county area served by Pennhurst. Thus plaintiffs' first argument is without merit.

Plaintiffs alternatively argue that Pennhurst violates section 504 by denying its residents the benefits of Pennsylvania's program of community living arrangements. This denial allegedly is based impermissibly upon the severity of the handicaps of those confined at Pennhurst.

Significantly, Pennsylvania accepts no federal funds for the operation of its community living arrangements, choosing instead to finance the program out of its own revenues. In 1976, Pennsylvania served 2069 persons in community living arrangements, 483 of whom were from the five-county region served by Pennhurst. During 1976, Pennhurst itself served approximately 1200 residents. As places have become available in community living arrangements in the five-county area, Pennsylvania has filled half of them with residents of Pennhurst and half with other retarded individuals.

Plaintiffs would have us hold that this system violates section 504 because only the most severely handicapped persons are placed at Pennhurst. Almost fifty percent of Pennhurst's residents are profoundly retarded, having I.Q.'s of less than 20. Almost three quarters are at least severely retarded, with I.Q.'s of less than 36. In addition, many of the residents are multiply handicapped. Although, given proper facilities, all of these persons could be served "in the community," no one disputes that such severely handicapped persons pose difficult placement problems. Moreover, plaintiffs do not contend that Pennsylvania has now, or has ever had, adequate facilities

in the community to cope with all, most, or even many of Pennhurst's present residents. Plaintiffs' only argument is that such facilities are feasible and that Pennsylvania violates section 504 by failing to develop them.

Presumably, such an expanded program of community living arrangements could be funded by federal grants under Titles XIV and XX of the Social Security Act, 42 U.S.C. §§1351 *et seq.*, 1397 *et seq.* Four states, Michigan, Minnesota, Nebraska, and Oklahoma, presently finance such programs under these titles. Section 504, however, cannot be read as requiring states to accept federal funds for such a program. On the contrary, in his comments on the Rehabilitation Act of 1972, which included a provision identical to section 504 as enacted, Congressman Badillo specified that the Act would allow states "to explore the possibility of using, as much as possible, a community-based treatment approach. . . ." 118 Cong. Rec. 36,414 (Oct. 14, 1972). Plaintiffs now argue that Pennsylvania, which has chosen to use its own funds to "explore the possibility of using" community living arrangements, violates section 504 in failing to embrace that treatment approach completely and immediately. Because the legislative history reveals no more than a congressional intent to encourage deinstitutionalization, I believe that such a conclusion is untenable.

Therefore, I reject each of plaintiffs' arguments that institutionalization of the mentally retarded at Pennhurst violates section 504. Because that section supports neither the plaintiffs nor the majority, I must proceed to consider the other bases for the district court's order.

C. *Pennsylvania Law*

The majority holds that Pennsylvania's Mental Health and Mental Retardation Act of 1966 (MH&MRA), 50 P.S. §§4101 *et. seq.*, grants the retarded a statutory right to treatment and that the plaintiffs have a private cause of action under the statute to enforce that right. The majority seems to implicitly rest its least restrictive treatment rule in part on Pennsylvania law.

I will assume that the residents of Pennhrust have a statutory right to some kind of treatment under the 1966 legislation. I cannot say as a matter of Pennsylvania law, however, that whatever treatment the residents are entitled to receive must be provided in the least restrictive environment possible. The question is: If the deplorable conditions evidenced in the record were eliminated at Pennhurst, would some individual still have an absolute right as a matter of state law to be placed in a less restrictive setting?

Initially, as with any implied cause of action, the remedy must be tied to violation of an express statutory provision. General language may not obscure the need for concrete imposition of a specific duty. Article II of the MH&MRA sets out the duties of the state and nowhere does it mention a duty to provide the least restrictive treatment regardless of fiscal concerns.

Moreover, the structure of the MH&MRA itself implies that Pennsylvania's General Assembly, in enacting the legislation, contemplated no such absolute right to treatment outside a properly run institution if such were the least restrictive environment imaginable. A major purpose of the MH&MRA was to ensure proper division

of responsibilities between the state's Department of Public Welfare (DPW) and local authorities, primarily cities and counties. *See* 50 P.S. §§4102, 4202(a), 4301(d), 4507(a)(1). This division of authority indicates that DPW was to operate regional facilities like Pennhurst while the localities were to concentrate on community-based services such as after-care. The very fact that both exist side by side in the legislative scheme without any language about placement in one or the other belies any theory that the General Assembly intended an absolute right to one to the exclusion of the other.

Buttressing my conclusion that the MH&MRA contemplated institutionalization of the mentally retarded are statistics, cited by the district court, indicating that institutionalization as a means of providing for the retarded was on the rise through 1966, the year of the MH&MRA's enactment. *See* 446 F. Supp. at 1300 n.7. The record shows that only in 1970 did Pennsylvania begin to explore the possibility of deinstitutionalizing Pennhurst's residents. *See* 446 F. Supp. at 1312. I believe it would be anomalous to attribute to the General Assembly of 1966 an intention to require treatment of the mentally retarded in a community setting because it would be less restrictive than an institution when the state did not even consider community treatment until 1970.

Nor do I believe that intervening changes in attitudes toward habilitation of the mentally retarded allow this court to reject the legislative judgment, implicit in the MH&MRA, that institutions, if properly run, can provide the mentally retarded with the requisite services. The General Assembly has not indicated that it has reached a contrary conclusion. Furthermore, the only Pennsyl-

vania courts to consider analogous issues seem to have assumed that institutionalization is permissible without examining it as the least restrictive alternative under the MH&MRA. For example, in *Hoolick v. Retreat State Hospital,* 24 Pa. Commw. Ct. 218, 354 A.2d 609 (1976), *aff'd mem.,* 476 Pa. 317, 382 A.2d 739 (1978), the Commonwealth Court rejected a claim that the MH&MRA required DPW to continue to operate the Retreat State Hospital. In so ruling, the court noted that the hospital was "an institution within the framework of mental health facilities operated by the Commonwealth . . ." *Id.* at 220, 354 A.2d at 610. According to the Commonwealth Court:

> The manifest object of the General Assembly in enacting the Mental Health and Mental Retardation Act of 1966 was to create a cooperative State-county (or multi-county) program across the Commonwealth for those who suffer mental health or mental retardation afflictions. . . . To retard or restrict State action in the operation of such a program, a clear specific legislative intent that a particular mental health facility shall remain functional would be required.

Id. at 224, 354 A.2d at 612. Thus under *Hoolick,* the legislature gave the DPW wide latitude in choosing what type of an institution best suits an individual.

Moreover, the state's duty to treat individuals is subject to the financial limitations of its own treasury. *Cf. County of Allegheny v. Commonwealth,* 33 Pa. Commw. Ct. 267, 381 A.2d 1014 (1978) (state's liability to county not absolute). Indeed, in one case, the county placed an individual in a private home; because this was not au-

thorized by the Act, the state was not liable to the county for the expenditure. *In the interest of Wayne K.*, 34 Pa. Commw. Ct. 10, 382 A.2d 989 (1978). At the least, then, the state right to treatment does not include a right to placement in a private home, even if that is the least restrictive environment.

Absent legislative action indicating that a particular type of facility, acceptable to the General Assembly in 1966, no longer passes legislative muster, I cannot predict that a Pennsylvania court facing this same question would hold that an individual has an absolute right to treatment in another less restrictive institution. I would hold only that, according to Pennsylvania law, any right the mentally retarded may have under the MH&MRA to habilitation can be satisfied in an institutional setting properly maintained.

II. CONSTITUTIONAL BASIS

A. *Due Process*

The final question presented by the plaintiffs is the constitutionality of the state statutory scheme of institutionalizing people in Pennhurst. The district court held that retarded persons, once admitted to a state facility, "have a constitutional right [under the due process clause] to be provided with minimally adequate habilitation under the least restrictive conditions consistent with the purpose of the commitment." 446 F. Supp. at 1319. Having found such a right, the district court further held that Pennhurst, because it is an institution, could never provide minimally adequate habilitation, and that Pennhurst's residents were entitled to be placed in community living arrangements. 446 F. Supp. at 1318, 1320.

The majority holds that some individuals may remain in Pennhurst, thus rejecting the district court's thesis. It purports to do this on statutory grounds, thereby avoiding the constitutional issue. The majority's apparent justification for failing to reach the constitutional issue is that the legislation involved here does not require less than is mandated by the Constitution. The majority merely makes this statement without explaining why its unarticulated view of the Constitution is correct and the district court's theory is incorrect. If, as I believe, the statutes in question provide no cause of action to enforce a generalized absolute right to least restrictive treatment, then the only remaining basis for the majority's holding is the Constitution.

My approach presents two questions. First, decide what are the permissible governmental purposes that support civil commitment of the mentally retarded. Second, determine whether those purposes are sufficient to support institutionalization or whether the state has a constitutional duty to employ means less restrictive of individual freedom.

In finding a constitutional right to habilitation, the district court relied on a series of cases that grant nondangerous mental patients who are involuntarily committed a right to psychiatric treatment. The seminal right-to-treatment case was *Rouse v. Cameron,* 373 F.2d 451 (D.C. Cir. 1966), which dealt with a statutory right to treatment. In dictum, the court indicated that the failure to treat a mental patient who had been committed by the state was sufficiently "shocking" to violate due process guarantees. *See id.* at 455.

A number of courts have expanded upon *Rouse's* dictum. The Court of Appeals for the Fifth Circuit offered the strongest defense of the right to treatment in *Donaldson v. O'Connor,* 493 F.2d 507 (5th Cir. 1974), *vacated on other grounds and remanded,* 422 U.S. 563 (1975), and *Wyatt v. Aderholt,* 503 F.2d 1305 (5th Cir. 1974), *aff'g, Wyatt v. Stickney,* 325 F. Supp. 781 (M.D. Ala. 1971) (*Stickney I*). *Donaldson* noted that involuntary confinement must be justified by a legitimate state purpose to survive scrutiny under the due process clause. *See Jackson v. Indiana,* 406 U.S. 715, 738 (1972). Historically, civil commitment had been based on one of three grounds: danger to self, danger to others, or need for treatment. *See id.* at 737. Because uncontradicted evidence demonstrated that Donaldson was dangerous neither to himself nor to others, the only legitimate basis for his confinement was the provision of treatment. According to the Fifth Circuit, the state of Florida, which confined Donaldson to treat him, had a constitutional duty to provide him with adequate and effective treatment, the "quid pro quo" for his confinement. *See* 493 F.2d at 518-27.[3]

The first case to apply the right-to-treatment rationale to the mentally retarded was *Wyatt v. Stickney,* 344 F. Supp. 387 (M.D. Ala. 1972) (*Stickney II*), *affirmed in relevant part sub nom. Wyatt v. Aderholt,* 503 F.2d 1305 (5th Cir. 1974). Having determined in *Stickney I* that persons involuntarily committed to mental institutions had a right to treatment the district court felt compelled to

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[3] The Supreme Court in *Donaldson* stopped short of endorsing the quid-pro-quo approach. *See O'Connor v. Donaldson,* 422 U.S. 563, 576 (1975). Our court has specifically reserved ruling on the theory. *See Scott v. Plante,* 532 F.2d 939, 947 (3d Cir. 1976).

extend an analogous right to the mentally retarded. *See* 344 F. Supp. at 390.[4]

I can assume, without deciding, that a non-dangerous individual committed by the state because of an alleged mental illness has a right to receive psychiatric treatment for his or her condition. I do not agree, however, with the assertion made in *Stickney II* that, in this regard, "no viable distinction can be made between the mentally ill and the mentally retarded." 344 F. Supp. at 390. On the contrary, as the Supreme Court has noted in another context, "careful attention must be paid to the differences between [the] mentally ill and [the] mentally retarded. . . ." *Kremens v. Bartley,* 431 U.S. 119, 135-36 (1977). In particular, I believe that the government's purpose in depriving Pennhurst's residents of their liberty is quite different from the government's purpose in depriving a non-dangerous, mentally ill person of his or her liberty.

As noted earlier, the Supreme Court has identified three conditions that might justify civil commitment: danger to self, danger to others, and need for treatment. *See Jackson v. Indiana,* 406 U.S. 715, 737 (1972). In *O'Connor v. Donaldson,* 422 U.S. 563, 574 n.9 (1975), the Supreme Court briefly examined the "danger to self"

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[4] Since 1972, a number of courts have followed *Stickney II* and have held that mentally retarded persons confined in state-run institutions have a constitutional right to habilitation. *See, e.g., Welsch v. Likins,* 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part and vacated and remanded in part,* 550 F.2d 1122 (8th Cir. 1977). In each of these cases, however, the court concluded or assumed that the state could provide the necessary habilitation in an institutional setting. *See, e.g., Gary W. v. Louisiana,* 437 F. Supp. 1209, 1217-19 (E.D. La. 1976).

rationale and indicated that it considered inability to care for oneself a permissible basis for civil commitment:

> Of course, even if there is no foreseeable risk of self-injury or suicide, a person is literally "dangerous to himself" if for physical or other reasons he is helpless to avoid the hazards of freedom either through his own efforts or with the aid of willing family members or friends.

No one disputes that most, if not all, of Pennhurst's residents are dangerous to themselves in this sense. Severely or profoundly retarded often with multiple handicaps, the residents obviously are unable to fend for themselves. Nor, as the district court's findings on voluntariness make clear, are there "willing family members or friends" available to shield them from the "hazards of freedom."

I believe that the residents' inability to live independently distinguishes this case from *Donaldson* and other cases granting non-dangerous mental patients a right to treatment. Moreover, I believe that the state's willingness to provide the residents with such necessities as food, shelter, medical care, and supervision for which the residents have no other source, forms an adequate basis for some state-imposed restrictions on their liberty.

I am left, of course, with the question whether the residents' need for care and supervision justifies the magnitude of the restraint imposed by institutionalization. The Court of Appeals for the Fifth Circuit has argued that it does not. In *Wyatt v. Aderholt,* 503 F.2d 1305, 1313 (5th Cir. 1974) (affirming *Stickney I* and *Stickney II*), the court emphasized that commitment entailed

" 'massive curtailments' of individual liberty." The court continued:

> Against the sweeping personal interest involved, [the state of Alabama] would have us weigh the state's interest, and the interests of the friends and families of the mentally handicapped in having private parties relieved of the "burden" of caring for the mentally ill. The state interest thus asserted may be strictly speaking, a "rational" state interest. But we find it so trivial beside the major personal interests against which it is to be weighed that we cannot possibly accept it as a justification for the deprivations of liberty involved.

Several factors persuade me to reject *Wyatt's* reasoning in the context of this case. First, that decision preceded the Supreme Court's decision in *Donaldson.* As noted, the Supreme Court there indicated that the need to provide mentally handicapped persons with custodial care could, under some circumstances, support civil commitment. Moreover, to the extent that *Wyatt's* reasoning survived *Donaldson,* the realities of Pennhurst as recorded in the findings of the district court preclude its application in this case. The vast majority, almost 90 per cent, of Pennhurst's residents are 18 years of age or older. Under Pennsylvania law the duty of parents or relatives to contribute to the support of an unmarried person who has been committed or who is receiving services under the MH&MRA terminates upon that person's attainment of 18 years of age. *See* 50 P.S. §4502. Moreover, relatives and friends who will accept responsibility for the care of Pennhurst's residents either do not exist or are unwilling or unable to do so. The district

court found that 43 per cent of the residents have had no family contact in the past three years. The record does not show what percentage of the residents have family members still living. *See* 446 F. Supp. at 1302 & n.16. Even as to those residents under the age of 18, the district court found that Pennhurst "was and is their only alternative," *id.* at 1311 (footnote omitted), and that "they have no place else to go," *id.* at 1318. Given these findings, defendants are doing far more than relieving otherwise willing and able relatives of the burden of caring for the residents; they are acting as the residents' only source of food, shelter, supervision, and medical care. Far from being "trivial," these services are a matter of life or death to the residents. *See generally New York State Association for Retarded Children, Inc. v. Rockefeller,* 357 F. Supp. 752, 759-60 (E.D.N.Y. 1973), *consent judgment approved,* 393 F. Supp. 715 (E.D.N.Y. 1975), *aff'd,* 596 F.2d 27 (2d Cir.), *cert. denied,* 48 U.S.L.W. (Oct. 2, 1979). *But see Gary W. v. Louisiana,* 437 F. Supp. 1209, 1217 (E.D. La. 1976) (all members of plaintiff class were minor children).

Having concluded that the residents' need for care and supervision can support significant restrictions on their personal liberty, it nevertheless must be decided whether Pennsylvania must provide for the residents' needs in a manner least restrictive of those liberties, or whether it is sufficient that the restrictions be rationally related to the purpose of confinement. The district court here felt that *Shelton v. Tucker,* 364 U.S. 479 (1960), required use of less drastic means in general, and community living arrangements in particular. In *Shelton* the Supreme Court considered an Arkansas statute requiring every teacher to file an annual affidavit listing all or-

ganizations to which he or she belonged or contributed. In striking down the requirement as an unconstitutional abridgment of first amendment freedoms, the Court held that

> even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.

Id. at 488 (footnotes omitted).

It is quite possible that the Supreme Court has already rejected the contention that *Shelton's* less-drastic-means analysis applies to the conditions of civil commitment. *See State v. Sanchez,* 80 N.M. 438, 457 P.2d 370 (1968) (mentally ill), *dismissed for want of a substantial federal question,* 396 U.S. 276 (1970). *See generally Mandel v. Bradley,* 432 U.S. 173 (1977) (per curiam); *Hicks v. Miranda,* 422 U.S. 332 (1975); *Halderman v. Pennhurst State School & Hospital,* 446 F. Supp. at 1319 n.55; *Patton v. Dumpson,* 425 F. Supp. 621, 624 (S.D. N.Y. 1977). Nevertheless, I believe that the importance of this issue merits a full examination of plaintiffs' argument.

In two cases dealing directly with the conditions and duration of civil confinement the Supreme Court has not been required to reach the question whether a state must provide its mental health services in a manner least restrictive of fundamental liberties. In *Jackson v. Indiana,* 406 U.S. 715 (1972), the Court examined

the constitutionality of a statutory scheme that permitted indefinite, and probably permanent, commitment of a person adjudged incompetent to stand trial on criminal charges. In holding that this procedure deprived the petitioner of due process of law, the Court reasoned that "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." *Id.* at 738. Similarly, in *O'Connor v. Donaldson, supra,* 422 U.S. at 576, the Court explored the minimum protection afforded by due process, holding that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom. . . ." In both *Jackson* and *Donaldson* the challenged restrictions were invalidated under this minimal scrutiny. But by employing the phrases "at the least" and "without more," the Supreme Court left open the possibility that it might apply stricter scrutiny in a proper case.

Recently, in *Bell v. Wolfish,* 99 S.Ct. 1861 (1979), the Supreme Court considered the constitutional requirements for the conditions under which pre-trial detainees may be confined. The plaintiff detainees, who were confined solely because of their inability to post bail, complained, *inter alia,* that the practice of assigning two detainees to a cell designed for one person denied them due process of law. In upholding the constitutionality of "double-bunking" the Supreme Court declined to apply the "compelling necessity" test that had been adopted by the Court of Appeals for the Second Circuit. Instead, the majority focused on whether double-bunking constituted infliction of punishment, and phrased the standard of review as whether a particular condition or re-

striction of pretrial detention is reasonably related to a legitimate governmental objective. . . ." *Id.* at 1874.

Bell, although dealing with the conditions of non-criminal confinement, is not dispositive of the standard of review to be applied in this case. The plaintiffs in *Bell* did not contend that double-bunking, as opposed to single-bunking, was unduly restrictive of any express constitutional guarantee. *See id.* at 1871. In this case, however, plaintiffs argue that institutions, when compared with community living arrangements, are more restrictive of such fundamental rights as freedom to travel and freedom of association. Assuming this to be the case, I will consider the applicability of some sort of less-drastic-means analysis.

The Supreme Court first formalized less-drastic-means analysis in *Shelton v. Tucker,* 364 U.S. 479, 488 (1960). Prior to that decision, the consideration of less restrictive alternatives was at least implicit in a number of opinions. *See The Supreme Court, 1960 Term,* 75 Harv. L. Rev. 40, 129 (1961) (collecting cases). Those earlier decisions, however, tended to treat less drastic alternatives as only one consideration in the overall assessment of an enactment's reasonableness. *Compare Shelton v. Tucker, supra,* at 488-90, *with id.* at 493-94 (Frankfurter. J., dissenting). In *Shelton* the Court seemed to hold that the existence of less drastic means would almost always invalidate a statute that impinged upon "fundamental personal liberties." *See id.* at 488.

Since 1960, application of less-drastic-means analysis has been far from uniform. *See, e.g., United States v. Robel,* 389 U.S. 258, 267 (1967) ("It is not our function . . . to determine whether an industrial security

screening program exhausts the possible alternatives to the statute under review."); L. Tribe, American Constitutional Law 722-23 (1978); Note, *Less Drastic Means and the First Amendment,* 78 Yale L. Rev. 464, 464-65 (1969). Moreover, even in the prototypical situation, where an allegedly overbroad statute impinges upon first amendment guarantees, the Supreme Court has been extremely cautious in employing the analysis. *See* Note, *supra,* at 472. Carried to its logical extreme less-drastic-means analysis is, as Justice Blackmun has noted, a "slippery slope":

> A judge would be unimaginative indeed if he could not come up with something a little less "drastic" or a little less "restrictive" in almost any situation, and thereby enable himself to vote to strike legislation down.

Illinois State Board of Elections v. Socialist Workers Party, 99 S.Ct. 983, 993 (1979) (Blackmun, J., concurring).

I engage in this overview not to suggest abandonment of less-drastic-means analysis, but to emphasize the care with which it must be employed. In the proper context this mode of analysis is a useful instrument for detecting unconstitutional overbreadth. I believe, however, that the present case falls outside that context.

Implicit in rigid application of less-drastic-means analysis is a presumption that, absent countervailing governmental interest, an individual benefits from unfettered freedom. In some circumstances, of course, societal interests prevail and mandate restriction of that freedom.

Nevertheless, the search for less drastic means is a judicial attempt to ensure that the intrusion is as small as possible.

This model falters where the individual, in the Supreme Court's words, is "helpless to avoid the hazards of freedom." *O'Connor v. Donaldson, supra,* 422 U.S. at 574 n.9. In such a case, the very purpose of the governmental intrusion is to prevent the individual from exercising his or her freedom in a self-destructive manner. Analytically, the difficulty is not an absence of less drastic means; in theory there will be some perfect balance between freedom and supervision, some "least restrictive alternative." Instead, the difficulty I perceive is a judicial inability to strike the perfect balance in any particular case. In an influential article cited with approval in *Shelton,* Elliot Richardson pinpointed the advantage of less-drastic-means analysis over the traditional balancing of interests employed by courts in first amendment cases:

> With the question whether the restriction of expression is a necessary means of protecting some other interest, we come back to judgments of a more objective character. The efficacy of the restriction of speech as such a means . . . [is] a matter as to which it could more easily be said than in the case of the value of a threatened interest that a legislative judgment was or was not plainly wrong. The same is true of the question whether other means are available.

Richardson, *Freedom of Expression and the Function of Courts,* 65 Harv. L. Rev. 1, 40 (1951). *See* 364 U.S. at 488 n.9. It is this objectivity, this ability to identify a single, better alternative, that commends less-drastic-means analysis.

This objectivity, however, counsels against use of the doctrine in the manner utilized by the district court. Here, there is not one ideal balance between freedom and supervision, but 1200, one for each of Pennhurst's residents. Some residents are capable of surviving with only minimal supervision. Others require complete, if temporary, physical restraint. *See* 446 F. Supp. at 1328. This complexity precludes a single, objective solution, making use of less-drastic-means analysis to declare institutions, per se unconstitutional particularly inappropriate.

The problem is not solved by arguing that less-drastic-means analysis requires individualized determinations rather than condemnation of institutions as a class. In the first place, what is the least restrictive environment for any particular individual is primarily a medical question. As the record demonstrates, this concept is an uncertain one and has been the subject for fervent medical debate. I feel it inappropriate for courts to make such a judgment on the basis of a doctrine that contemplates an objective, single better alternative. Second, the least restrictive alternative for any particular individual will change over time. Thus there is no single and final solution—the heart of the less-drastic-means analysis—for each individual. By imposing upon a state a constitutional duty to provide its custodial care in the least restrictive manner, almost every decision concerning the care of a mentally retarded person would be subjected to ongoing judicial review.

Plaintiffs cannot salvage their proposed analysis by labelling community living arrangements as *the* least restrictive alternative. The definitional elasticity of the

term "community living arrangement"[5] renders such an argument quite circular. Whether this setting is called a community living arrangement or something else, the federal courts would still be required to balance each resident's need for supervision and care against that resident's ability to cope with personal liberty. Such decisions traditionally, and I believe properly, have been left in the hands of physicians and mental health administrators.

Drawing from *Jackson, Donaldson,* and *Bell,* I would hold that where the state confines[6] a person against his or her will because of an inability of that person "to avoid the hazards of freedom," the conditions of that con-

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[5] Indeed, the record indicates that community living arrangements tend to be all things to all people. They apparently range from simple provision of support services so that a retarded person can remain with his or her family to subsidized foster care to mini-institutions of over 20 residents. The "community" is variously defined as urban, suburban, or rural. Stewart Brown, one of the plaintiffs' witnesses, illustrated the malleability of this concept when he was pressed on his contention that all of Pennhurst's residents could be dispersed to community living arrangements within one month:

> A: . . . There are seventy-one Holiday Inns in Pennsylvania with 11,208 rooms, and we could, with a *per diem* rate move those clients and provide an immediate place for them to live where they would be happy—
>
> Q: All right. Let's talk about community-living arrangements.
>
> A: That's one type of community-living arrangement.

[6] Plaintiffs have not challenged in this appeal the adequacy of the procedures under which they were committed or placed at Pennhurst. *See generally Secretary of Public Welfare of Pennsylvania v. Institutionalized Juveniles,* 47 U.S.L.W. 4754 (June 20, 1979).

finement must bear a reasonable relationship to the purpose of the confinement. I do not believe that a state can be constitutionally required to care for that person in a manner "least restrictive" of that person's freedom. Nevertheless, the availability of less drastic alternatives is one factor for a court to consider in determining the overall reasonableness of the challenged restraint. *See, e.g., Bell v. Wolfish, supra,* 99 S.Ct. at 1885 n.40.

In applying this standard of review to the case at bar, I again must stress that what is at issue here is not whether it is constitutional to place persons in Pennhurst as it existed when this record was created. There can be no question that Pennhurst is not providing its residents with minimally adequate supervision and care. Instead, the question is the constitutionality of institutions as they should be operated.

Moreover, my rejection of less-drastic-means analysis does not mean that I conceive of a "properly run institution" as a monolithic concept unrelated to the needs of particular individuals. What may be the appropriate treatment very likely will vary from person to person within the institution. The test I choose—a right to treatment rationally related to the purpose of the state-imposed restraints on liberty—applies to every individual, whether inside or outside an institution. Thus in my view, the phrase "properly run institution" means properly run as to all those confined in it. Given the current medical definition of retardation and the fact that I do not know what a properly run Pennhurst would be like, I leave for future cases the question of whether a particular individual placed in an institution free of the deplorable conditions in the record here would ever have a constitutional right to treatment in a different environment.

With these caveats in mind, I conclude that institutionalization is not a constitutionally unreasonable means of providing for the care and supervision of the mentally retarded. A large-scale institution is quite capable of providing its residents with adequate food, shelter, medical care, and other necessities. Moreover, given the residents' need for such services, an institution does not necessarily restrict their liberty in an unreasonable fashion. I am not dissuaded from this conclusion by the feasibility of less restrictive, more effective, or even less expensive methods of caring for the retarded.[7]

The choice among models for the care of the retarded properly rests with state authorities. Federal courts may not interfere with that choice unless the selected model is not a reasonable means of delivering the services that support civil commitment in the first place. I leave for future cases the determination of whether a given method of treatment is not rationally related to the state's objective in confining a particular individual.

B. *Equal Protection*

The district court also held that confinement at Pennhurst violated the equal protection clause of the fourteenth amendment because it entailed "segregation in

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[7] Supporting my conclusion that institutionalization is not unconstitutionally unreasonable are those cases that, although finding a constitutional right to habilitation, have permitted the state to continue to provide that habilitation in an institutional setting. *See e.g., Gary W. v. Louisiana, supra,* 437 F. Supp. at 1217-19; *Wyatt v. Stickney, (Stickney II), supra,* 344 F. Supp. at 395-407. *See also Wyatt v. Aderholt, supra,* 503 F.2d at 1313 (institutionalization is, "strictly speaking," rationally related to need for custodial care).

a facility that clearly is separate and *not* equal." 446 F. Supp. at 1322 (emphasis in original). As in the case of their due process claim, plaintiffs' equal protection claim turns primarily on the proper level of judicial scrutiny to be applied to institutionalization of the mentally retarded.

Initially, I reject plaintiffs' contention that mental retardation qualifies as a "suspect classification." In *Doe v. Colautti,* 592 F.2d 704, 710-11 (3d Cir. 1979), we held that mental illness was not a suspect classification. We noted that, under *Massachusetts Board of Retirement v. Murgia,* 427 U.S. 307, 313 (1976) (per curiam), "a class is not entitled to special solicitude under the Equal Protection Clause unless the members of the class have 'been subjected to unique disabilities on the basis of stereotyped characteristics not truly indicative of their abilities.' " 592 F.2d at 711. Applying this rule to the mentally ill, we noted:

> Although the mentally ill have been the victims of stereotypes, the disabilities imposed on them have often reflected that many of the mentally ill do have reduced ability for personal relations, for economic activity, and for political choice. This is not to say that the legal disabilities have precisely fit the actual incapacities of the mentally ill individuals whom the law has burdened, but it is important that the legal disabilities have been related, even if imperfectly, to real inabilities from which many of the mentally ill suffer.

Id. I believe that this reasoning is equally applicable to the mentally retarded.

Alternatively, plaintiffs argue that where a classification burdens fundamental liberties, the state must

show that the burden is necessary to achieve a "compelling" government interest. *See Shapiro v. Thompson,* 394 U.S. 618, 634 (1969). The state's interest in ensuring that these individuals receive adequate food, shelter, supervision, and medical care is compelling enough to justify the intrusion. Although *Shapiro* and other equal protection cases may imply that the state must employ less drastic means if they are available, *see, e.g.,* 394 U.S. at 637, I believe this analysis is inapposite for the reasons given in my discussion of the due process claim.

For these reasons I believe that, although Pennsylvania has classifiled the residents by institutionalizing them, such a classification is reasonably related to a legitimate, compelling state interest.

C. *Eighth Amendment*

The district court finally found that Pennhurst violated the residents' "Eighth and Fourteenth Amendment right to freedom from harm." 446 F. Supp. at 1320. To the extent that this alleged right would parallel the right to be free from punishment, recognized in *Bell v. Wolfish,* 99 S.Ct. 1861 (1979), I have already expressed my view that institutionalization of the mentally retarded is "reasonably related to a legitimate government objective. . . ." *See id.* at 4512. To the extent that the alleged right to be free from harm, founded in the eighth amendment, would exceed the protection outlined in *Bell,* I do not believe the district court's analysis survives that decision.

III. *Summary*

I agree with the majority that plaintiffs have a right to have Pennhurst brought up to statutory and constitu-

tional standards. I nowhere find a right to treatment in the least restrictive environment. Thus I would reverse those portions of the district court's judgment that contemplate a federal-court-ordered closing of Pennhurst or creation of new, less restrictive facilities. Although some portions of the order dealt with conditions at Pennhurst, because the district court ordered it closed it did not deal extensively with that problem. Therefore, I would remand to the district court for it to decide in the first instance how best to bring Pennhurst in compliance with statutory and constitutional requirements. Finally, I leave open the possibility that certain individuals in the future may be able to show that their particular mode of treatment is not rationally related to the state's purpose in confining them.

The majority's definition of habilitation has real emotional appeal. But its implementation is being provided by doctors, experts, and legislators. There is a danger in a case such as this that a court will permit the technical data to provide the sole basis for a legal rule where the problem is essentially medical.

Furthermore, the majority's conclusion implicates massive and continual involvement of the federal judiciary in the multiple problems of the mentally retarded. I disagree with the majority because I cannot find any basis for holding that a federal court may require the state to create facilities for the retarded that the court deems to be the least restrictive. That is a right that, in my view, neither Pennsylvania nor federal legislation nor the Constitution gives to the plaintiffs.

A True Copy:
Teste:

Clerk of the United States Court of Appeals for the Third Circuit

REHABILITATION ACT OF 1973, SECTION 504 (29 U.S.C. §794)

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§794. Nondiscrimination under federal grants and programs; promulgation of rules and regulations

No otherwise qualified handicapped individual in the United States, as defined in section 706(7) of this title, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance or under any program or activity conducted by any Executive agency or by the United States Postal Service. The head of each such agency shall promulgate such regulations as may be necessary to carry out the amendments to this section made by the Rehabilitation, Comprehensive Services, and Developmental Disabilities Act of 1978. Copies of any proposed regulation shall be submitted to appropriate authorizing committees of the Congress, and such regulation may take effect no earlier than the thirtieth day after the date on which such regulation is so submitted to such committees.

* * *

DEVELOPMENTALLY DISABLED ASSISTANCE AND BILL OF RIGHTS ACT

* * *

(42 U.S.C. §§6000, 6010-11, 6061-63, 6065)

SUBCHAPTER I—GENERAL PROVISIONS

§6000. Congressional declaration of findings and purpose

(a) The Congress finds that—

(1) there are more than two million persons with developmental disabilities in the United States;

(2) individuals with disabilities occurring during their developmental period are more vulnerable and less able to reach an independent level of existence than other handicapped individuals who generally have had a normal developmental period on which to draw during the rehabilitation process;

(3) persons with developmental disabilities often require specialized lifelong services to be provided by many agencies in a coordinated manner in order to meet the persons' needs;

(4) general service agencies and agencies providing specialized services to disabled persons tend to overlook or exclude persons with developmental disabilities in their planning and delivery of services; and

(5) it is in the national interest to strengthen specific programs, especially programs that reduce or eliminate

the need for institutional care, to meet the needs of persons with developmental disabilities.

(b) (1) It is the overall purpose of this chapter to assist States to assure that persons with developmental disabilities receive the care, treatment, and other services necessary to enable them to achieve their maximum potential through a system which coordinates, monitors, plans, and evaluates those services and which ensures the protection of the legal and human rights of persons with developmental disabilities.

(2) The specific purposes of this chapter are—

(A) to assist in the provision of comprehensive services to persons with developmental disabilities, with priority to those persons whose needs cannot be covered or otherwise met under the Education for All Handicapped Children Act, the Rehabilitation Act of 1973, or other health, education, or welfare programs;

(B) to assist States in appropriate planning activities;

(C) to make grants to States and public and private, nonprofit agencies to establish model programs, to demonstrate innovative habilitation techniques, and to train professional and paraprofessional personnel with respect to providing services to persons with developmental disabilities;

(D) to make grants to university affiliated facilities to assist them in administering and operating demonstration facilities for the provision of services to persons with developmental disabilities, and inter-

disciplinary training programs for personnel needed to provide specialized services for these persons; and

(E) to make grants to support a system in each State to protect the legal and human rights of all persons with developmental disabilities.

* * *

§6010. Congressional findings respecting rights of developmentally disabled

Congress makes the following findings respecting the rights of persons with developmental disabilities:

(1) Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities.

(2) The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.

(3) The Federal Government and the State both have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that—

(A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons; or

(B) does not meet the following minimum standards:

(i) Provision of a nourishing, well-balanced daily diet to the persons with developmental disabilities being served by the program.

(ii) Provision to such persons of appropriate and sufficient medical and dental services.

(iii) Prohibition of the use of physical restraint on such persons unless absolutely necessary and prohibition of the use of such restraint as a punishment or as a substitute for a habilitation program.

(iv) Prohibition on the excessive use of chemical restraints on such persons and the use of such restraints as punishment or as a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation for such persons.

(v) Permission for close relatives of such persons to visit them at reasonable hours without prior notice.

(vi) Compliance with adequate fire and safety standards as may be promulgated by the Secretary.

(4) All programs for persons with developmental disabilities should meet standards which are designed to assure the most favorable possible outcome for those served, and—

(A) in the case of residential programs serving persons in need of comprehensive health-related, habilitative, or rehabilitative services, which are at least equivalent to those standards applicable to intermediate care facilities for the mentally retarded promulgated in regulations of the Secretary on January 17, 1974 (39 Fed. Reg. pt. II), as appropriate when taking into account the size of the institutions and the service delivery arrangements of the facilities of the programs;

(B) in the case of other residential programs for persons with developmental disabilities, which assure that care is appropriate to the needs of the persons being served by such programs, assure that the persons admitted to facilities of such programs are persons whose needs can be met through services provided by such facilities, and assure that the facilities under such programs provide for the humane care of the residents of the facilities, are sanitary, and protect their rights; and

(C) in the case of nonresidential programs, which assure the care provided by such programs is appropriate to the persons served by the programs.

* * *

The rights of persons with developmental disabilities described in findings made in this section are in addition to any constitutional or other rights otherwise afforded to all persons.

* * *

§6011. Habilitation plans

Condition for receipt of state allotment

(a) The Secretary shall require as a condition to a State's receiving an allotment under subchapter III of this chapter that the State provide the Secretary satisfactory assurances that each program (including programs of any agency, facility, or project) which receives funds from the State's allotment under such part (1) has in effect for each developmentally disabled person who receives services from or under the program of a habilitation plan meeting the requirements of subsection (b) of this section, and (2) provides for an annual review, in accordance with subsection (c) of this section, of each such plan.

Requirements

(b) A habilitation plan for a person with developmental disabilities shall meet the following requirements:

(1) The plan shall be in writing.

(2) The plan shall be developed jointly by (A) a representative or representatives of the program primarily responsible for delivering or coordinating the delivery of services to the person for whom the plan is established, (B) such person, and (c) where appropriate, such person's parents or guardian or other representative.

(3) The plan shall contain a statement of the long-term habilitation goals for the person and the intermediate habilitation objectives relating to the attainments of such goals. Such objectives shall be stated specifically and in sequence and shall be expressed in behavioral or other terms that provide measurable indices of progress. The plan shall (A) describe how the objectives will be achieved and the barriers that might interfere with the achievement of them, (B) state objective criteria and an evaluation procedure and schedule for determining whether such objectives and goals are being achieved, and (C) provide for a program coordinator who will be responsible for the implementation of the plan.

(4) The plan shall contain a statement (in readily understandable form) of specific habilitation services to be provided, shall identify each agency which will deliver such services, shall describe the personnel (and their qualifications) necessary for the provision of such services, and shall specify the date

of the initiation of each service to be provided and the anticipated duration of each such service.

(5) The plan shall specify the role and objectives of all parties to the implementation of the plan.

Annual review

(c) Each habilitation plan shall be reviewed at least annually by the agency primarily responsible for the delivery of services to the person for whom the plan was established or responsible for the coordination of the delivery of services to such person. In the course of the review, such person and the person's parents or guardian or other representative shall be given an opportunity to review such plan and to participate in its revision.

* * *

§6061. Authorization of appropriations

For allotments under section 6062 of this title, there are authorized to be appropriated $40,000,000 for fiscal year 1976, $50,000,000 for fiscal year 1977, $60,000,000 for fiscal year 1978, $55,000,000 for the fiscal year ending September 30, 1979, $65,000,000 for the fiscal year ending September 30, 1980, and $75,000,000 for the fiscal year ending September 30, 1981.

* * *

§6062. Allotments to States

Determination of amount

(a) (1) In each fiscal year, the Secretary shall, in accordance with regulations and this paragraph, allot the sums appropriated for such year under section 6061 of this title among the States on the basis of—

(A) the population,

(B) the extent of need for services for persons with developmental disabilities, and

(C) the financial need,

of the respective States. Sums allotted to the States under this section shall be used in accordance with approved State plans under section 6063 of this title for the provision under such plans of services for persons with developmental disabilities.

(2) For any fiscal year, the allotment under paragraph (1)—

(A) to each of American Samoa, Guam, the Virgin Islands, the Northern Mariana Islands, or the Trust Territory of the Pacific Islands may not be less than $100,000, and

(B) to any other State may not be less than the greater of $250,000, or the amount of the allotment (determined without regard to subsection (d) of this section) received by the State for the fiscal year ending September 30, 1978.

(3) In determining, for purposes of paragraph (1)(B), the extent of need in any State for services for persons with developmental disabilities, the Secretary shall take into account the scope and extent of the services described, pursuant to section 6063(b)(2)(B) of this title, in the State plan of the State.

* * *

Apportionment of allotment among State agencies

(b) Whenever the State plan approved in accordance with section 6063 of this title provides for participa-

tion of more than one State agency in administering or supervising the administration of designated portions of the State plan, the State may apportion its allotment among such agencies in a manner which, to the satisfaction of the Secretary, is reasonably related to the responsibilities assigned to such agencies in carrying out the purposes of the State plan. Funds so apportioned to State agencies may be combined with other State or Federal funds authorized to be spent for other purposes, provided the purposes of the State plan will receive proportionate benefit from the combination.

Combined allotments to State involved in joint effort

(c) Whenever the State plan approved in accordance with section 6063 of this title provides for cooperative or joint effort between States or between or among agencies, public or private, in more than one State, portions of funds allotted to one or more such cooperating States may be combined in accordance with the agreements between the agencies involved.

Reallotment of funds not required by State

(d) The amount of an allotment to a State for a fiscal year which the Secretary determines will not be required by the State during the period for which it is available for the purpose for which allotted shall be available for reallotment by the Secretary from time to time, on such date or dates as he may fix (but not earlier than thirty days after he has published notice of his intention to make such reallotment in the Federal Register), to other States with respect to which such a determination has not been made, in proportion to the original allotments of such States for such fiscal year, but with such

proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Secretary estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly reallotted among the States whose proportionate amounts were not so reduced. Any amount so reallotted to a State for a fiscal year shall be deemed to be a part of its allotment under subsection (a) of this section for such fiscal year.

* * *

§6063. State plans

Submission and approval

(a) Any State desiring to take advantage of this subchapter must have a State plan submitted to and approved by the Secretary under this section.

Conditions for approval

(b) In order to be approved by the Secretary under this section, a State plan for the provision of services for persons with developmental disabilities must meet the following requirements:

(1) (A) The plan must provide for the establishment of a State Planning Council, in accordance with section 6067 of this title, for the assignment to the Council of personnel in such numbers and with such qualifications as the Secretary determines to be adequate to enable the Council to carry out its duties under that section, and for the identification of the personnel so assigned.

(B) The plan must designate the State agency or agencies which shall administer or supervise the administration of the State plan and, if there is more

than one such agency, the portion of such plan which each will administer (or the portion the administration of which each will supervise).

(C) The plan must provide that each State agency designated under subparagraph (B) will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to verify such reports.

(D) The plan must provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the State under this subchapter.

(2) The plan must—

(A) set out the specific objectives to be achieved under the plan and a listing of the programs and resources to be used to meet such objectives;

(B) describe (and provide for the review annually and revision of the description not less often than once every three years) (i) the extent and scope of services being provided, or to be provided, to persons with developmental disabilities under such other State plans for Federally assisted State programs as the State conducts relating to education for the handicapped, vocational rehabilitation, public assistance, medical assistance, social services, maternal and child health, crippled children's services, and comprehensive health and mental health, and under such other plans as the Secretary may specify, and (ii) how funds allotted to the State in accordance with

section 6062 of this title will be used to complement and augment rather than duplicate or replace services for persons with developmental disabilities which are eligible for Federal assistance under such other State programs;

(C) for each fiscal year, assess and describe the extent and scope of the priority services (as defined in section 6001 (8) (B) of this title) being or to be provided under the plan in the fiscal year; and

(D) establish a method for the periodic evaluation of the plan's effectiveness in meeting the objectives described in subparagraph (A).

(3) The plan must contain or be supported by assurances satisfactory to the Secretary that—

(A) the funds paid to the State under section 6062 of this title will be used to make a significant contribution toward strengthening services for persons with developmental disabilities through agencies in the various political subdivisions of the State;

(B) part of such funds will be available by the State to public or nonprofit private entities;

(C) such funds paid to the State under section 6062 of this title will be used to supplement and to increase the level of funds that would otherwise be made available for the purposes for which Federal funds are provided and not to supplant such non-Federal funds; and

(D) there will be reasonable State financial participation in the cost of carrying out the State plan.

(4) (A) The plan must—

(i) provide for the examination not less often than once every three years of the provision, and the need for the provision, in the State of the four different areas of priority services (as defined in section 6001 (8) (B) of this title; and

(ii) provide for the development, not later than the second year in which funds are provided under the plan after November 6, 1978, and the timely review and revision of a comprehensive statewide plan to plan, financially support, coordinate, and otherwise better address, on a statewide and comprehensive basis, unmet needs in the State for the provision of at least one of the areas of priority services, such area or areas to be specified in the plan, and (at the option of the State) for the provision of an additional area of services for the developmentally disabled, such area also to be specified in the plan.

(B) (i) Except as provided in clause (iii), the plan must provide that not less than $100,000 or 65 percent of the amount available to the State under section 6062 of this title, whichever is greater, will be expended, as provided in clause (ii), for service activities in the areas of services specified in the plan under subparagraph (A) (ii).

(ii) For any year in which the sums appropriated under section 131 do not exceed—

(I) $60,000,000, not less than $100,000 or 65 percent of the amount available to the State under section 6062 of this title, whichever is greater, must be expended for service activities in no more

than two of the areas of services specified in the plan under subparagraph (A) (ii), and

(II) $90,000,000, not less than $100,000 or 65 percent of the amount available to the State under section 6062 of this title, whichever is greater, must be expended for service activities in no more than three of the areas of services specified in the plan under subparagraph (A) (ii).

(iii) A State, in order to comply with clause (i) for a fiscal year beginning before January 1, 1980, is not required to reduce the amount which is available to it under section 6062 of this title and which is expended for planning activities below the amount so expended for planning activities in the preceding fiscal year, if substantially the remainder of the amount available to the State, which is expended for other than administration, is expended for service activities in the areas of services specified in the plan under subparagraph (A) (ii). For purposes of this clause, expenditures for planning activities do not include any expenditures for service activities (as defined in clause (iv)).

(iv) For purposes of this subparagraph, the term "service activities" includes, with respect to an area of services, provision of services in the area, model service programs in the area, activities to increase the capacity of institutions and agencies to provide services in the area, coordinating the provision of services in the area with the provision of other services, outreach to individuals for the provision of services in the area, the training of personnel to provide services in the area, and similar

activities designed to expand the use and availability of services in the area.

(C) Notwithstanding subparagraph (B), upon the application of a State, the Secretary, pursuant to regulations which the Secretary shall prescribe, may permit the portion of the funds which must otherwise be expended under the State plan for service activities in a limited number of areas of services to be expended for service activities in additional areas of services if he determines that the expenditures of the State on service activities in the initially specified areas of services has reasonably met the need for those services in the State in comparison to the extent to which the need for such additional area or areas of services has been met in such State. Such additional areas shall, to the maximum extent feasible, be areas within the areas of priority services (as defined in section 6001 (8) (B) of this title).

(D) The plan must provide that special financial and technical assistance shall be given to agencies or entities providing services for persons with developmental disabilities who are residents of geographical areas designated as urban or rural poverty areas.

(5) (A) (i) The plan must provide that services furnished, and the facilities in which they are furnished, under the plan for persons with developmental disabilities will be in accordance with standards prescribed by the Secretary in regulations.

(ii) The plan must provide satisfactory assurances that buildings used in connection with the

delivery of services assisted under the plan will meet standards adopted pursuant to the Act of August 12, 1968 (known as the Architectural Barriers Act of 1968).

(B) The plan must provide that services are provided in an individualized manner consistent with the requirements of section 6011 of this title (relating to habilitation plans).

(C) The plan must contain or be supported by assurances satisfactory to the Secretary that the human rights of all persons with developmental disabilities (especially those persons without familial protection) who are receiving treatment, services, or habilitation under programs assisted under this chapter will be protected consistent with section 6010 of this title (relating to rights of the developmentally disabled).

(D) The plan must provide assurances that the State has undertaken affirmative steps to assure the participation in programs under this chapter of individuals generally representative of the population of the State, with particular attention to the participation of members of minority groups.

(6) The plan must provide for—

(A) an assessment of the adequacy of the skill level of professionals and paraprofessionals serving persons with developmental disabilities in the State and the adequacy of the State programs and plans supporting training of such professionals and paraprofessionals in maintaining the high quality of services provided to persons with developmental disabilities in the State; and

(B) the planning and implementation of an evaluation system (in accordance with section 6009 (a) of this title).

(7) (A) The plan must provide for the maximum utilization of all available community resources including volunteers serving under the Domestic Volunteer Service Act of 1973 (Public Law 93-113) and other appropriate voluntary organizations, except that such volunteer services shall supplement, and shall not be in lieu of, services of paid employees.

(B) The plan must provide for fair and equitable arrangements (as determined by the Secretary after consultation with the Secretary of Labor) to protect the interests of employees affected by actions under the plan to provide alternative community living arrangement services (as defined in section 6001 (8) (E) of this title), including arrangements designed to preserve employee rights and benefits and to provide training and retraining of such employees where necessary and arrangements under which maximum efforts will be made to guarantee the employment of such employees.

(8) The plan also must contain such additional information and assurances as the Secretary may find necessary to carry out the provisions and purposes of this subchapter.

Approval of conforming plan; notice and hearing prior to final disapproval

(c) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection (b) of this section. The Secretary

shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

Administrative expenditures; Limitation of amount; payments; advances or reimbursement, Installments

(d) (1) At the request of any State a portion of any allotment or allotments of such State under this subchapter for any fiscal year shall be available to pay one-half (or such smaller share as the State may request) of the expenditures found necessary by the Secretary for the proper and efficient administration of the State plan approved under this section; except that not more than 5 per centum of the total of the allotments of such State for any fiscal year, or $50,000, whichever is less; shall be available for the total expenditures for such purpose by all of the State agencies designated under subsection (b) (1) (B) of this section for the administration or supervision of the administration of the State plan. Payments under this paragraph may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine.

(2) Any amount paid under paragraph (1) to any State for any fiscal year shall be paid on condition that there shall be expended from the State sources for such year for administration of the State plan approved under this section not less than the total amount expended for such purposes from such sources during the previous fiscal year.

* * *

§6065. Withholding of payments to States for planning, administration, and services

Whenever the Secretary, after reasonable notice and opportunity for hearing to the State Planning Council and

the appropriate State agencies or agency, designated pursuant to section 6063 (b) (1) of this title finds that—

(1) there is a failure to comply substantially with any of the provisions required by section 6063 of this title to be included in the State plan; or

(2) there is a failure to comply substantially with any regulations of the Secretary which are applicable to this subchapter,

the Secretary shall notify such State Council and agency or agencies that further payments will not be made to the State under section 6062 of this title (or, in his discretion, that further payments will not be made to the State under section 6062 of this title for activities in which there is such failure), until he is satisfied that there will no longer be such failure. Until he is so satisfied, the Secretary shall make no further payment to the State under section 6062 of this title, or shall limit further payment under section 6062 of this title to such State to activities in which there is no such failure.

* * *

45 C.F.R. §1385.1

SUBCHAPTER I—THE ADMINISTRATION FOR HANDICAPPED INDIVIDUALS, DEVELOPMENTAL DISABILITIES PROGRAM

Part 1385—General

* * *

§1385.1 Purpose of Act.

The purpose of the Act is to improve and coordinate the provision of services to persons with developmental disabilities and to establish a system for the protection and advocacy of rights for persons with developmental disabilities through:

(a) Grants to assist the States in developing and implementing a comprehensive and continuing plan for identifying and meeting the needs of the developmentally disabled;

(b) Support of activities which contribute to improving the condition of persons with developmental disabilities;

(c) Renovation and modernization of university affiliated facilities which demonstrate the provision of services for the demonstration and interdisciplinary training programs in university affiliated facilities;

(d) Training specialized personnel needed for providing such services;

(e) Provision of technical assistance in the establishment of services and facilities for the developmentally disabled; and

(f) Development and demonstration of new and improved techniques for providing such services.

To these ends, Federal financial assistance is available through (1) basic support formula grants to States; (2) formula grants to States for effecting a system to protect and advocate the rights of developmentally disabled persons; (3) grants to university affiliated facilities and for satellite centers; and (4) grants to public and private nonprofit groups for demonstration projects and projects of national significance.

* * *

45 C.F.R. §1386.42—.43

* * *

Chapter XIII—Office of Human Development, Dept. of HEW

§1386.42 Deinstitutionalization.

The State plan goals, objectives, and strategies shall address: (a) The elimination of inappropriate placement in institutions of persons with developmental disabilities, and (b) the improvement of the quality of care and the state of surroundings of persons who are appropriately placed in institutions.

§1386.43 Establishment of community program alternatives to institutionalization.

The State plan shall support the establishment of community programs as alternatives to institutionalization and support such programs designed to provide services for the care and habilitation of persons with developmental disabilities, and which utilize, to the maximum extent feasible, the resources and personnel in related community programs to assure full coordination with such programs and to assure the provision of appropriate supplemental health, educational, or social services for persons with developmental disabilities.

* * *

FEDERAL RULES OF CIVIL PROCEDURE

* * *

Rule 53. Masters.

(a) APPOINTMENT AND COMPENSATION. Each district court with the concurrence of a majority of all the judges thereof may appoint one or more standing masters for its district, and the court in which any action is pending may appoint a special master therein. As used in these rules the word "master" includes a referee, an auditor, an examiner, a commissioner, and an assessor. The compensation to be allowed to a master shall be fixed by the court, and shall be charged upon such of the parties or paid out of any fund or subject matter of the action. which is in the custody and control of the court as the court may direct. The master shall not retain his report as security for his compensation; but when the party ordered to pay the compensation allowed by the court does not pay it after notice and within the time prescribed by the court, the master is entitled to a writ of execution against the delinquent party.

(b) REFERENCE. A reference to a master shall be the exception and not the rule. In actions to be tried by a jury, a reference shall be made only when the issues are complicated; in actions to be tried without a jury, save in matters of account and of difficult computation of damages, a reference shall be made only upon a showing that that some exceptional condition requires it.

(c) POWERS. The order of reference to the master may specify or limit his powers and may direct him to report only upon particular issues or to do or perform particular acts or to receive and report evidence only and may fix the time and place for beginning and closing the hearings and for the filing of the master's report. Subject to the specifications and limitations stated in the order, the master has and shall exercise the power to regulate all proceedings in every hearing before him and to do all acts and take all measures necessary or proper for the efficient performance of his duties under the order. He may require the production before him of evidence upon all matters embraced in the reference, including the production of all books, papers, vouchers, documents, and writings applicable thereto. He may rule upon the admissibility of evidence unless otherwise directed by the order of reference and has the authority to put witnesses on oath and may himself examine them and may call the parties to the action and examine them upon oath. When a party so requests, the master shall make a record of the evidence offered and excluded in the same manner and subject to the same limitations as provided in Rule 43 (c) for a court sitting without a jury.

(d) PROCEEDINGS.

(1) *Meetings.* When a reference is made, the clerk shall forthwith furnish the master with a copy of the order of reference. Upon receipt thereof unless the order of reference otherwise provides, the master shall forthwith set a time and place for the first meeting of the parties or their attorneys to be held within 20 days after the date of the order of reference and shall notify the parties or their attorneys. It is the duty of the master to

proceed with all reasonable diligence. Either party, on notice to the parties and master, may apply to the court for an order requiring the master to speed the proceedings and to make his report. If a party fails to appear at the time and place appointed, the master may proceed *ex parte* or, in his discretion, adjourn the proceedings to a future day, giving notice to the absent party of the adjournment.

(2) *Witnesses.* The parties may procure the attendance of witnesses before the master by the issuance and service of subpoenas as provided in Rule 45. If without adequate excuse a witness fails to appear or give evidence, he may be punished as for a contempt and be subjected to the consequences, penalties, and remedies provided in Rules 37 and 45.

(3) *Statement of Accounts.* When matters of accounting are in issue before the master, he may prescribe the form in which the accounts shall be submitted and in any proper case may require or receive in evidence a statement by a certified public accountant who is called as a witness. Upon objection of a party to any of the items thus submitted or upon a showing that the form of statement is insufficient the master may require a different form of statement to be furnished, or the accounts or specific items thereof to be proved by oral examination of the accounting parties or upon written interrogatories or in such other manner as he directs.

(e) REPORT.

(1) *Contents and Filing.* The master shall prepare a report upon the matters submitted to him by the order of reference and, if required to make findings of fact and

conclusions of law, he shall set them forth in the report. He shall file the report with the clerk of the court and in an action to be tried without a jury, unless otherwise directed by the order of reference, shall file with it a transcript of the proceedings and of the evidence and the original exhibits. The clerk shall forthwith mail to all parties notice of the filing.

(2) *In Non-Jury Actions.* In an action to be tried without a jury the court shall accept the master's findings of fact unless clearly erroneous. Within 10 days after being served with notice of the filing of the report any party may serve written objections thereto upon the other parties. Application to the court for action upon the report and upon objections thereto shall be by motion and upon notice as prescribed in Rule 6(d). The court after hearing may adopt the report or may modify it or may reject it in whole or in part or may receive further evidence or may recommit it with instructions.

(3) *In Jury Actions.* In an action to be tried by a jury the master shall not be directed to report the evidence. His findings upon the issues submitted to him are admissible as evidence of the matters found and may be read to the jury, subject to the ruling of the court upon any objections in point of law which may be made to the report.

(4) *Stipulation as to Findings.* The effect of a master's report is the same whether or not the parties have consented to the reference; but, when the parties stipulate that a master's findings of fact shall be final, only questions of law arising upon the report shall thereafter be considered.

(5) *Draft Report.* Before filing his report a master may submit a draft thereof to counsel for all parties for the purpose of receiving their suggestions.

* * *

PENNSYLVANIA MENTAL HEALTH AND MENTAL RETARDATION ACT

(50 P.S. §§4201, 4202(a), 4301(a), (d), 4507(a)(2), 4509(1), (5))

* * *

§4201. General powers and duties of the department

The department shall have power, and its duty shall be:

(1) To assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them, regardless of religion, race, color, national origin, settlement, residence, or economic or social status.

(2) To make, with the advice of the Advisory Committee for Mental Health and Mental Retardation and enforce all regulations necessary and appropriate to the proper accomplishment of the mental health and mental retardation duties and functions imposed by this act. Such regulations shall not become effective until the department shall have given the local authorities thirty days written notice of the proposed regulations and afforded the local authorities the opportunity for a hearing before the department on the proposed regulations.

(3) To consult with and assist each county in carrying out mental health and mental retardation duties and functions and where necessary after thirty days written notice to the counties affected and an opportunity for such counties for a hearing before the department and with the advice of the Advisory Committee for Mental

Health and Mental Retardation to require two or more counties to join in establishing a program to provide the services required by this act.

(4) To adopt State-wide plans for the operation of all State operated facilities under the jurisdiction of the department and to assign to each facility or portion thereof, such duties for the care of the mentally disabled, as the secretary shall prescribe. The assignments herein referred to shall be made with due regard to geographical location and population distribution.

(5) To establish and maintain working relationships with other governmental bodies and public and private agencies, institutions and organizations so as to assure maximum utilization of services and facilities which each such governmental body and public and private agency, institution and organization may have, which may be of benefit to the mentally disabled.

(6) To appoint such regional mental health and mental retardation boards as may be necessary to advise the department in the establishment, administration and review of mental health and mental retardation programs.

(7) To make grants, pay subsidies, purchase service and provide reimbursement for mental health and mental retardation services in accordance with this act.

(8) To supervise mental health and mental retardation facilities, services and programs as provided by law. 1966, Special Sess. No. 3, Oct. 20, P.L. 96, art. II, §201.

* * *

§4202. State facilities

(a) The department shall operate all State facilities and shall assign such functions to each as the secretary shall prescribe.

* * *

ARTICLE III. RESPONSIBILITIES OF COUNTIES

§4301. General powers and duties of local authorities; mental health and mental retardation program and services

(a) The local authorities of each county separately or in concert with another county or counties, as the secretary may approve, shall establish a county mental health and mental retardation program for the prevention of mental disability, and for the diagnosis, care, treatment, rehabilitation and detention of the mentally disabled and shall have power to make appropriations for such purposes. Such program shall conform with regulations of the department promulgated under section 202 (2).

* * *

(d) Subject to the provisions of sections 508 and 509 (5) it shall be the duty of local authorities in cooperation with the department to insure that the following mental health and mental retardation services are available:

(1) Short term inpatient services other than those provided by the State.

(2) Outpatient services.

(3) Partial hospitalization services.

(4) Emergency services twenty-four hours per day which shall be provided by, or available within at least one of the types of services specified heretofore in this paragraph.

(5) Consultation and education services to professional personnel and community agencies.

(6) Aftercare services for persons released from State and County facilities.

(7) Specialized rehabilitative and training services including sheltered workshops.

(8) Interim care of mentally retarded persons who have been removed from their homes and who having been accepted, are awaiting admission to a State operated facility.

(9) Unified procedures for intake for all county services and a central place providing referral services and information.

* * *

§4507. Liability of the Commonwealth

(a) Except as provided in section 501, 502, and 505, the Commonwealth shall pay for the following:

* * *

(2) Such other obligations as may arise under any new program established by the department.

* * *

§4509. State grants and payments

The department, subject to the provisions of section 503, shall have the power, and its duty shall be:

(1) From State and Federal funds, to make annual grants to counties to defray part of the cost of county programs authorized by this act and approved by the department, in the amount of ninety per cent of the excess of all such approved expenditures for such programs over

the amount paid for the same purpose from any public or private source directly to participating counties, facilities or individuals.

* * *

(5) In the event that sufficient funds to pay the full amount of the grants to which the counties may be entitled under the provisions of this section have not been appropriated, to distribute State funds among the counties by a formula reasonably designed to achieve the objectives of this act, provided however, that in such event the counties' financial obligations under this act shall be reduced in accordance with the same formula and the counties shall be required to provide only those services for which sufficient funds are available.

* * *

ACT OF PENNSYLVANIA GENERAL ASSEMBLY, NOVEMBER 27, 1970

Session of 1970. Act No. 256

No. 256

A SUPPLEMENT

SB 1304

To the act of November 25, 1969 (P.L. 310), entitled "An act providing for the capital budget for the fiscal year 1969-1970," itemizing public improvement projects to be acquired or constructed by the General State Authority, together with their estimated financial costs.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short Title.—This act shall be known and may be cited as the "Capital Budget Act for Fiscal Year 1969-1970, Public Improvement Project Itemization Supplement—General State Authority."

Section 2. Itemization and Authorization of Projects.—Additional capital projects in the category of public improvement projects to be acquired or constructed by the General State Authority, its successors or assigns, and to be financed by the incurring of debt, are hereby itemized, together with their respective estimated financial costs and the total additional amount authorized for public improvement projects, as follows:

A.	Total Project Authorization	$442,047,860
	I. Department of Agriculture	883,000
	(1) Regional Office: District No. 6 ..... (Base Construction Cost $321,000)	401,000
	(2) Regional Office: District No. 3 ..... (Land Acquisition $450,000)	482,000
	II. Department of Commerce	17,661,573
	(1) Cover for Delaware Avenue: Penn's Landing, Philadelphia ..... (Base Construction Cost $3,000,000)	4,036,573
	(2) Additional Funds for GSA 650-1, Philadelphia Civic Center ..... (Base Construction Cost $1,500,000)	1,875,000
	(3) Additional Funds for GSA 1201-1, Convention-Exposition Center, City of Pittsburgh ..... (Base Construction Cost $9,378,000)	11,750,000
	III. Department of Forests and Waters	32,279,050
	(1) Flood Protection Project: Blakely Borough ..... (Base Construction Cost $782,000)	978,000
	(2) Flood Protection Project: Glenside Area ..... (Base Construction Cost $618,000)	773,000

(3) Flood Protection Project:
Philipsburg Area 795,000
(Base Construction Cost $636,000)

(4) Inflatable Dam: Pine Creek 278,000
(Base Construction Cost $222,000)

* * *

(118) Women's Medical
College 1,783,332
Additional authorization required as the college share for the clinical teaching and service building (GSA 1107-1). When this project is leased by the authority to the Department of Education, the department shall sublease this portion of the project to the medical college for the same aggregate rentals as this portion of the authority's lease to the department, upon terms and conditions as shall be agreed to. This provision shall not be applicable to that portion of the project previously designated as the authority share.

(119) Additional Funds for
GSA 1505-5, Physical Education
Center and Land Acquisition:
Drexel University 2,500,000
(Base Construction Cost $2,000,000)

(120) Additional Funds for University of Pennsylvania's share of new facility for Children's Hospital of Philadelphia to be used for service to the University as its Pediatric Division 13,199,048
(Base Construction Cost $12,191,185)

X. Department of Public Welfare	56,354,945
(1) Utility Distribution System: Dixmont State Hospital ..... (Base Construction Cost $2,480,000)	3,100,000
(2) Water Distribution System: Mayview State Hospital ..... (Base Construction Cost $205,000)	256,250
(3) Electric System in South-2 Annex Building: Mayview State Hospital ..... (Base Construction Cost $168,000)	210,000
(4) Increase Capacity, Main Sub-Station: Philadelphia State Hospital ..... (Base Construction Cost $400,000)	500,000
(5) Renovate Steam Supply and Return System: Philadelphia State Hospital ..... (Base Construction Cost $600,000)	750,000
(6) Additional Funds for GSA 514-17, Specialized Therapeutic Activity Facility: Warren State Hospital .. (Base Construction Cost $100,000)	125,000
(7) New Water Distribution System: Woodville State Hospital ..... (Base Construction Cost $540,000)	675,000
(8) Renovation of Electrical Distribution System: Woodville State Hospital ..... (Base Construction Cost $2,250,000)	2,813,000

(9) Renovation of Electrical Distribution System-Phase II: Cresson State School and Hospital ..... (Base Construction Cost $893,000)	1,116,250
(10) Renovation of Electrical Distribution System-Phase III: Laurelton State School and Hospital ..... (Base Construction Cost $1,266,000)	1,583,000
(11) Renovation of Utilities: Pennhurst State School and Hospital .... (Base Construction Cost $2,142,000)	2,678,000
(12) Renovation of Patient Building-Female 1: Pennhurst State School and Hospital ..... (Base Construction Cost $1,840,000)	2,300,000
(13) Renovation of Patient Building-Female 2: Pennhurst State School and Hospital ..... (Base Construction Cost $1,840,000)	2,300,000
(14) Additional Funds for GSA 551-14, Patient Building for Hyperactive Children, Air Conditioning: Pennhurst State School and Hospital ..... (Base Construction Cost $310,000)	387,500
(15) New Boiler Plant: Polk State School and Hospital ..... (Base Construction Cost $3,094,000)	3,868,000
(16) Additional Funds for GSA 518-1, Altoona Geriatric Center .. (Base Construction Cost $2,097,000)	2,620,345

(17) Additional Funds for GSA 534-5, Main Hospital Building and Renovate Maternity Wing: Hazleton State General Hospital 1,468,800
(Base Construction Cost $1,175,000)

(18) Renovations to Boiler Plant: Scranton State General Hospital 250,000
(Base Construction Cost $200,000)

(19) Philadelphia Diagnostic and Rehabilitation Center 2,649,800
(Base Construction Cost $2,000,000)
(Land Acquisition $140,000)

(20) Construction of Annex to Philadelphia State Hospital for Resident Treatment Addiction Center for Rehabilitation of Alcoholics and Narcotics Patients: St. Lukes and Children's Medical Center, Philadelphia .. 5,625,000
(Base Construction Cost $4,500,000)

(21) For planning, design and construction of mental retardation service units; and, acquisition of property, total population survey and social system analysis as required to provide definitive treatment and normalizing accomodations for mentally retarded residents of Bucks, Chester, Delaware, Montgomery and Philadelphia Counties and to be located in the same counties. The units are to provide accommodations for approximately 900 patients to reduce the population at

Pennhurst State School and Hospital to a maximum of 1,000. This capital investment to provide logical dispersal and reorientation into the community for Pennhurst residents and alternatives to institutionalization for the Pennhurst waiting list population and other mentally retarded citizens of the area who require such treatment and accommodations. This program is to be completed as expeditiously as possible so that the first units may be occupied not later than two years from the effective date of this act 21,079,000
(Base Construction Cost, Acquisition, Survey and Analysis $16,863,000)

XI. Department of Revenue 562,500

(1) Driver Examination Point: Cumberland County 285,000
(Base Construction Cost $210,000)
(Land Acquisition $21,000)

(2) Driver Examination Point: Columbia County 277,500
(Base Construction Cost $210,000)
(Land Acquisition $14,000)

XII. Pennsylvania State Police 12,591,700

(1) Substation and Driver Examination Point: Bucks County 527,000
(Base Construction Cost $581,000)
(Land Acquisition $24,000)

(2) Troop Headquarters: Dauphin County ..... (Base Construction Cost $1,700,000)	2,125,000
(3) Substation: Delaware County ..... (Base Construction Cost $326,000) (Land Acquisition $24,000)	433,200
(4) Substation: Montgomery County ..... (Base Construction Cost $336,000) (Land Acquisition $24,000)	446,000
(5) Substation: Venango County ..... (Base Construction Cost $135,000)	168,750
(6) State Police Crime Laboratory Wyoming Barracks: Luzerne County ..... (Base Construction Cost $195,000)	243,750
(7) Regimental Headquarters: Dauphin County ..... (Base Construction Cost $6,71,000) (Land Acquisition $32,000)	8,423,000
XIII. Department of Transportation	900,000
(1) Emergency Equipment and Maintenaance Building, Olmstead State Airport ..... (Base Construction Cost $720,000)	900,000

Section 3. Allocation of Funds.—Whenever as determined by the General State Authority, the full estimated

financial cost of any of the public improvement projects itemized in section 2 hereof is not necessary for the proper design, acquisition or construction of such project, the excess funds no longer required may be allocated by the General State Authority to increase the estimated cost of any one or more of the public improvement projects specifically itemized in a capital budget.

Section 4. Effective Date.—This act shall take effect immediately.

APPROVED—The 27th day of November, A.D. 1970,
RAYMOND P. SHAFER

The foregoing is a true and correct copy of Act of the General Assembly No. 256.

(s) Joseph J. Kelley, Jr.
Secretary of the Commonwealth

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE

TITLE 6100 MH/MR PROGRAM
FISCAL MANUAL
for the
COUNTY MH/MR PROGRAM

Harrisburg July 1978

* * *

6111 Authority of the Department

The Department shall have the power to make grants, pay subsidies, purchase service and provide reimbursement for Mental Health and Mental Retardation Services, in accordance with the Act.

6111.1 Departmental Financial Participation

Subject to the appropriation of funds and pursuant to the Act and these regulations, the Department shall participate at 100% of the approved expenditures for the following: (1) Diagnosis, evaluation, and care in State-operated facilities, or in a facility with which the State may contract; (2) Payments for inpatient care not exceeding 60 days per benefit period, and partial hospitalization not exceeding 120 days, per year, for persons financially ineligible for such care under the Public Assistance Law; (3) Interim care of mentally retarded persons; (4) Community living arrangements for the mentally retarded; (5) Such other obligations as may arise under any new program established by the Department. For other services or activities qualifying for financial support under the County Pro-

gram, the Department shall participate at 90% of the approved expenditures. The remaining 10% is the county obligation or the local match of the County Program.

6111.11 Departmental Participation in New Programs

For a program to qualify for 100% Departmental participation as a "new program," it must be initiated and approved by the Department and it cannot be interpreted as falling under one of the mandated services in §301 (d) of the Act. Once a program is determined to meet the definition of "new" under the Act, it shall retain its 100% funding status for the duration of the program.

* * *

Supreme Court, U. S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

JOINT APPENDIX
VOLUME I, A241-A385

Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

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**Qualifications of expert witnesses were stipulated pre-trial, Curriculum vitae designated as PARC and US Exhibits, detailing education, experience, publications and other qualifications of all plaintiffs' witnesses are found in the Final Pre-Trial Order filed at R. 464, March 31, 1978.

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*Exhibits included herein were admitted into evidence at Tr. 1-36 to 1-43; and Tr. 1-49 to 1-56 and at Tr. 4-68.

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*Exhibits included herein were admitted into evidence at Tr. 1-36 to 1-43; and Tr. 1-49 to 1-56 and at Tr. 4-68.

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U.S. Ex. 48	Index of Photographic Exhibits of Pennhurst and Community Programs	A1161

Photographs admitted into evidence as U.S. Exhibit 48 are presented in a separate volume.

*Exhibits included herein were admitted into evidence at Tr. 1-36 to 1-43; and Tr. 1-49 to 1-56 and at Tr. 4-68.

The following opinions, decisions, judgments, orders and statutes have been omitted in printing this appendix because they appear on the following pages in the appendix to the printed Petition for Certiorari:

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CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

May 30, 1974	Complaint of plaintiffs Halderman et al. filed
November 25, 1974	Motion of United States to intervene as party plaintiff
January 17, 1975	Order granting motion of United States to intervene as party plaintiff
June 3, 1975	Motion of Pennsylvania Association for Retarded Children to intervene as party plaintiffs
October 6, 1975	Order enjoining defendants from admitting into Pennhurst any person adjudicated as delinquent
November 13, 1975	Order granting motion of Pennsylvania Association for Retarded Citizens et al., to intervene as party plaintiffs
January 8, 1976	Amended Complaint of Pennsylvania Association for Retarded Citizens filed
March 3, 1976	Plaintiff Halderman's motion for leave to file second amended complaint filed
April 5, 1976	Defendants' motion to dismiss plaintiff intervenor P.A.R.C.
November 30, 1976	Order granting leave to plaintiffs to file second amended complaint; ruling upon various motions to dismiss and ruling that litigation be maintained as a class action

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES — *(Continued)*

January 4, 1977	Order that defendants are enjoined from altering or removing anything from any records at Pennhurst subject to discovery
February 4, 1977	Order denying Commonwealth's motion to stay participation of United States
April 18, 1977	Order of Court of Appeals denying Commonwealth application for stay of further participation by United States
April 18, 1977	Trial commences
December 23, 1977	Opinion and Order of Broderick, J. finding constitutional and statutory rights of retarded residents of Pennhurst violated, and setting hearing to determine appropriate relief to be granted
March 17, 1978	Order entering judgment for plaintiffs and granting injunctive relief
May 9, 1978	Order of district court denying defendants' motion for a stay of the Order of 3/17/78
May 10, 1978	Notice of Appeal filed in U.S. Court of Appeals for the Third Circuit
June 21, 1978	Order of district court dismissing petition of Pennhurst Parents-Staff Association to intervene
June 30, 1978	Order appointing Special Master

CHRONOLOGICAL LIST
OF RELEVANT DOCKET ENTRIES — *(Continued)*

September 6, 1978	Order of Court of Appeals denying motion of Pennhurst Parent-Staff Association for leave to intervene without prejudice to pending appeal raising such issue
January 9, 1979	Appeal Argued. Coram: Seitz, Ch. J., Gibbons and Higginbotham, C.J.
July 6, 1979	Order listing cases for rehearing before the Court of Appeals *en banc*
August 6, 1979	Order of Court of Appeals granting partial stay of district court order of June 8, 1979
August 24, 1979	Order of Court of Appeals denying motion of AFSCME (Council 13) and its District Council 88, Amicus Curiae for leave to participate in oral argument
December 13, 1979	Judgment on Rehearing affirming the judgment of the district court except in three respects, Opinion of the Court of Appeals filed together with separate dissenting opinion
March 5, 1980	Order directing mandate reissue upon entry of order, granting motion of Pennhurst-Parent-Staff Association to intervene
March 12, 1980	Petitions for Certiorari filed by Commonwealth of Pennsylva-

	nia, Suburban Counties, Philadelphia; Conditional Cross Petition filed by P.A.R.C. et al.
March 20, 1980	Petition for Certiorari filed by Pennhurst Parent-Staff Association
May 12, 1980	Order of Court of Appeals denying motion of Pennhurst Parent-Staff Association for stay of district court orders pending certiorari
June 9, 1980	Petition for writ of certiorari granted
June 30, 1980	Order granting petitioners' motion for a stay of the judgment of the Court of Appeals, pending final disposition of the cases in the Supreme Court to the extent that the judgment mandates the movement of residents of the Pennhurst facility to "appropriate community living arrangements" and denying the motion in all other respects. Mr. Justice Brennan, Mr. Justice Marshall, Mr. Justice Blackmun and Mr. Justice Powell would have denied the motion.

District Court Opinion, May 9, 1978

Terri Lee HALDERMAN et al., Plaintiffs,

Pennsylvania Association for Retarded Citizens et al., Plaintiffs-Intervenors,

United States of America, Plaintiff-Intervenor,

v.

PENNHURST STATE SCHOOL AND HOSPITAL et al., Defendants.

Civ. A. No. 74-1345.

United States District Court, E. D. Pennsylvania.

May 9, 1978.

MEMORANDUM

RAYMOND J. BRODERICK, District Judge.

In an opinion filed on December 23, 1977, 446 F.Supp. 1295, this Court held that the constitutional and statutory rights of the retarded at Pennhurst State School and Hospital ("Pennhurst") had been and are being violated. As set forth in our memorandum of March 17, 1978, which accompanied the Court's Order in this case,

some of the determinations made by the Court in its opinion were:

> 1. That when a state institutionalizes individuals because they are retarded, the United States Constitution (Eighth and Fourteenth Amendments) and the laws of Pennsylvania (50 P.S. §§4101 et seq.) require the state to provide such minimally adequate habilitation as will afford a reasonable opportunity for them to acquire and maintain such life skills as are necessary to enable them to cope as effectively as their capacities permit.
>
> 2. That the Rehabilitation Act of 1973, 29 U.S.C. §794, grants rights to the retarded residents of Pennhurst, which rights have been and are being violated.
>
> 3. That the retarded at Pennhurst are not receiving minimally adequate habilitation and that such minimally adequate habilitation cannot be provided at Pennhurst because it does not provide an atmosphere conducive to normalization, which all the experts agree is vital to the minimally adequate habilitation of the retarded.

Based upon these and other determinations, this Court ordered appropriate injunctive relief. Commonwealth defendants and Bucks, Chester, Delaware, Montgomery and Philadelphia Counties have filed notices of appeal from the Court's judgment. The Commonwealth now seeks a stay of the judgment order pending a determination of its appeal by the Third Circuit.

[1,2] On April 13, 1978, a hearing was held in connection with the Commonwealth's motion to stay the judgment and, for the reasons hereinafter set forth, the motion will be denied.

Fed.R.Civ.P. 62(c) provides in pertinent part that:

> When an appeal is taken from an interlocutory or final judgment granting, dissolving, or denying an in-

> junction, the court in its discretion may suspend, modify, restore, or grant an injunction during the pendency of the appeal upon such terms as to bond or otherwise as it considers proper for the security of the rights of the adverse party.

It is well settled by the case law that a party seeking the stay of a judgment order must show (1) that it will likely prevail on the merits of the appeal, (2) that it will suffer irreparable injury if the stay is denied, (3) that other parties will not be substantially harmed by the stay, and (4) that the public interest will be served by granting the stay. *Philadelphia Counsel of Neighborhood Organizations v. Adams*, 451 F.Supp. 114 (E.D.Pa.1978); *Long v. Robinson*, 432 F.2d 977, 979 (4th Cir. 1970); *Resident Advisory Board v. Rizzo*, 429 F.Supp. 222, 224 (E.D.Pa.1977). A motion requesting a stay of a judgment order is addressed to the discretion of the court. The Third Circuit has recently stated that in considering the four-prong test enumerated above, the district court should realize that

> these [four] factors structure the inquiry, however, no one aspect will necessarily determine its outcome. Rather, proper judgment entails a "delicate balancing" of all elements.

Constructors Association of Western Pennsylvania v. Kreps, 573 F.2d 811, 815, (3d Cir. 1978). *See, Evans v. Buchanan*, 424 F.Supp. 875, 879 (D.Del.1976).

1. *Likelihood of Success on Appeal*[1]

Commonwealth defendants contend that "[t]his Court's decision and order are novel and precedent set-

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1. There is disagreement among the circuits as to the degree of likelihood of success which must be shown. *See Resident Advisory Board v. Rizzo*, 429 F.Supp. 222, 224 n.1 (E.D.Pa. 1977). We do not herein make any determination as to the degree of certainty which must be shown, since we find that the Commonwealth has not satisfied even the least rigorous of the standards, *i.e.*, mere likelihood of success on appeal.

ting, both in the rights enunciated and the scope of relief granted. . . . The novelty of the decision and order above is itself more than sufficient reason to grant a stay." However, as we have heretofore pointed out, the Court's judgment was based on several alternate legal theories, any one of which is sufficient to sustain the judgment. Several of these theories have been accepted by the courts which have considered them. See discussion of these cases in *Halderman v. Pennhurst*, 446 F.Supp. 1295, 1316-17, 1319 (ED.Pa.1977).

2. *Irreparable Injury to Commonwealth Defendants*

The Commonwealth contends that failure to stay the Court's Order of March 17, 1978 will cause irreparable injury in that compliance will require the expenditure of vast sums of money. In view of the testimony given by Commonwealth witnesses at trial that the Commonwealth intended to move all the retarded residents from Pennhurst into community facilities, the Commonwealth's contention that the Court's Order requiring this to be done will cause irreparable injury is unpersuasive. As the Court found in its opinion of December 23, 1977:

> Having concluded the trial phase of the liability portion of this litigation, it has become apparent that by and large the parties share the same goals: all desire to improve the education, training and care provided the retarded in Pennsylvania and believe that Pennhurst should be closed and that all residents should be educated, trained and cared for in the community. All agree that institutions such as Pennhurst are inappropriate and inadequate for the habilitation of the retarded. Defendants agree with plaintiffs' contention that the habilitation provided Pennhurst residents does not meet minimally acceptable professional standards. The Commonwealth in recent years has been attempting to up-

> grade Pennhurst and the education, training and care provided therein to its retarded residents. Moreover, the Pennsylvania Department of Public Welfare's current plans call for the transfer of all Pennhurst residents from the institution into the community (though perhaps temporarily into other institutions) by the early 1980's.
>
> *Halderman v. Pennhurst*, 446 F.Supp. at 1313.

The Commonwealth's irreparable injury argument becomes even less persuasive when one considers that in 1970, Act 256 was signed by the Governor of Pennsylvania. This Act appropriated $21,000,000 for the purpose of planning, designing and constructing community facilities which would enable 900 Pennhurst residents to be transferred to the community. As the record in this case shows, although seven and one-half years have gone by, few Pennhurst residents have been moved into community facilities pursuant to the legislation. Over $18,000,000 remains unspent. *Halderman v. Pennhurst*, 446 F.Supp. at 1311-1312.

The argument that the cost of compliance with the Court's Order will bring irreparable injury to the Commonwealth loses all credibility in light of the Court's finding that providing habilitative services for the retarded in the community is less expensive than operating a large isolated institution such as Pennhurst. As the Court found in its opinion of December 23, 1977:

> Comparable facilities in the community are generally less expensive than large isolated state institutions. Services can be purchased at regular rates, rather than at rates which must be paid to attract individuals to work in a setting like Pennhurst. The cost of running Pennhurst in 1976 was $27.8 million dollars, or $60 per resident per day. This does not include the fair rental value of the build-

> ings at Pennhurst (estimated at $3-$4 per resident per day). The statewide cost of community living arrangements in Pennsylvania for 1976 was $17.64 per individual per day. Program services, which one-third of mentally retarded individuals would need, average approximately $10 per individual per day. Moreover, keeping the retarded individual in the community makes it possible for him or her to get employment. Eighty-five percent of the mentally retarded can be employed, though not all are capable of competitive employment. The lifetime earnings of a mildly retarded individual often exceeds $500,000. For those with an I.Q. between 25 and 50, 45% of men and 12% of women earn about 20% of the average wage. When the retarded can work, the amount of financial support which society must provide decreases and the individuals may benefit society with the taxes they pay. Furthermore, the investment per individual at Pennhurst is primarily for warehousing and not for the individual's well-being or future planning, as is the case with community facilities.
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> *Halderman v. Pennhurst*, 446 F.Supp. at 1312 (citations omitted).

The Commonwealth also contends that it will lose federal financial assistance if the Court's Order is not stayed. Throughout the trial, the Commonwealth stressed the fact that retarded individuals residing in community living arrangements were not eligible for federal medical assistance funds (Title XIX) while those residing in Pennhurst were. However, in regulations published March 10, 1978, effective *October 1, 1976*, Title XIX funds became available to the eligible retarded living in public community residences housing no more than 16 persons. 42 C.F.R. §448.60, 43 Fed.Reg. 9810, 9816 (March 10, 1978). Moreover, the eligible retarded can now receive supplemental security income (SSI)

benefits. 20 C.F.R. §416.231(a)(4), 43 Fed.Reg. 4004, 4006 (January 31, 1978). Additionally, it appears that federal loans are now available for the construction of community facilities for the retarded pursuant to section 202 of the Housing Act of 1959, as amended, 12 U.S.C. §1701q. 24 C.F.R. §885, 43 Fed.Reg. 8492 (March 1, 1978).

The Court's judgment and order assures that the Commonwealth's own goals for the retarded are implemented and its contention that a failure to stay the judgment will bring irreparable injury is without merit.

3. *Injury to Plaintiffs from a Stay*

As the Court's opinion of December 23, 1977 demonstrates, the retarded residents of Pennhurst have endured severe and widespread deprivations of their constitutional and statutory rights — deprivations which continue to this day. The Court's Order of March 17, 1978 was designed to alleviate these deprivations. Delay in implementing that Order would result in further irreparable injury to the plaintiffs.

4. *Public Interest*

[3] Commonwealth defendants contend that the public interest would benefit from a stay. We do not agree. The public interest will never benefit from a failure to provide minimally adequate habilitation to its retarded citizens. This Court's Order represents nothing more than a judicial recognition that the retarded have constitutional and statutory rights which must not be denied.

[4] Having carefully considered all the contentions of the Commonwealth and having balanced the equities, we shall enter an Order denying the Commonwealth's motion requesting a stay of this Court's Order of March 17, 1978.

[Testimony of Philip Roos]

* * *

P. ROOS — direct

[1-85] BY MR. THRASHER:

Q. Dr. Roos, what is mental retardation, sir?

A. Mental retardation is essentially a problem of learning, a defect particularly of the individual's ability to think abstractly, to exercise judgments, to solve problems, and to retain information.

The definition of the American Association of Mental Deficiency is a generally-accepted one today
[1-86] and that defines mental retardation as significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behavior and manifestations during the developmental period, which refers to eighteen years of age or younger.

Usually we look at measured intelligence. A retarded individual scores on the test of general intelligence at least two standard deviations below the mean.

We also look at the child's adaptive behavior, and this refers to such things as sensory-motor development, self-help skills, language, vocalization; and in later life academic and social skills, the ability of the individual to cope with the environment and his vocational and social accomplishments.

Q. And how are these indicia measured, Dr. Roos?

A. Mental intelligence is usually measured in terms of so-called intelligence quotient or IQ. The average population score is 100. The retarded individuals usually score seventy or below.

Adaptive behavior is measured in terms of a social quotient, which is expressed in terms of essen-

tially a similar type of numerical score and which refers to the individual's ability to deal with the social environment.

Q. Are there any problems with these types of measurement of mental retardation?

[1-87] A. In recent years, particularly problems have become apparent in that the tests in common use a strong self-help bias and, in addition, performance is influenced by the individual's motivation, physically, anxiety, experiences, and whether or not he has learned to anticipate failure. Individuals who anticipate failure because of the fact of failure tend to do more poorly.

Q. Also, mental disease, mental illness, and mental retardation are confused.

Does mental retardation differ from mental illness?

A. Yes. They are two entirely different conditions.

Mental retardation refers primarily to a deficit in intellectual development and social adaptation, whereas mental illness refers to disorder of thinking, emotions, and behavior.

Mental retardation occurs usually either prior to, at, or shortly following birth; whereas mental illness can occur at any time in life and often the onset is during adulthood.

Mental retardation is primarily an educational problem; mental illness is primarily a psychiatric problem.

Whereas mental retardation is essentially irreversible, that is, although it can be improved, there is at this stage of our knowledge no cure; mental ill-

[1-88] ness is often reversible and curable.

* * *

BY MR. THRASHER

Q. Dr. Roos, can mentally-retarded persons, in addition to being mentally retarded, also be mentally ill?

A. Yes, they can, although most mentally-retarded persons are not mentally ill. There are some who in addition to mental retardation also suffer from a mental illness.

Q. Are the causes of mental retardation known today?

A. At least 250 separate causes have been recognized to today. However, in approximately seventy-five percent of the cases of mental retardation the cause is not known.

We do know that anyone who is responsible, that there are many potential conditions that will lead to mental retardation, including such diverse situations as infections in the mother during pregnancy, high fever in a young child, certain specific infections in the child, problems in nutrition, both in the pregnant mother and in the young child, inborn errors of metabolism, toxins in the entire system, such as lead, mercury, various types of unknown genetic conditions, certain hereditary situations, early environmental deprivations, and various kinds of trauma in nature; and these are just representative of some of the different types of conditions that may lead to retardation.

Q. Is mental retardation undifferentiated or are there different degrees of mental retardation?

A. There are different degrees of mental retardation. Essentially four basic levels are recognized today.

The mild level of mental retardation includes
[1-90] roughly eighty-nine percent of the mentally-retarded population, individuals whose IQs range between roughly fifty-two and sixty-seven.

The moderate degree of mental retardation includes six percent of the retarded population. These are individuals with IQs between thirty-six and fifty-two.

The severely mentally-retarded have IQs between twenty and thirty-five, and the most seriously incapacitated we refer to as those with profound mental retardation and they have IQs below twenty. Approximately twenty percent of the population fall in the severe and profound range.

BY THE COURT:

Q. You have combined those percentagewise?

A. I have combined those percentagewise. There are more severe than profound. Probably three to three and a half percent are the severe; the remainder are profound.

Q. Doctor, I may have put down the wrong numbers. Maybe it is not significant at all, but when you say eighty-nine percent generally fall within the mild category —

A. Right.

Q. — and six percent in the moderate?

A. In the moderate, —

Q. And then the remaining five?

A. The remaining five in the severe and profound.

THE COURT: I understand.

Let's proceed.

[1-91] BY MR. THRASHER:

Q. Dr. Roos, do you have any knowledge as to the prevalence or incidence rates of mental retardation in our society?

A. The general opinion today is that the incidence of mental retardation is less than three percent, suggesting then that some six and a half million United States citizens will at some time in their lives be labeled as mentally retarded.

The prevalence rate is probably close to two million at any one time.

Q. Have you made any determination as to the understanding of the public at large as to the condition of mentai retardation?

A. One of the big problems for the mentally-retarded person has been lack of general understanding. Indeed, there is a long history of myths, of distorted views on mental retardation which are still lingering today.

For instance, retarded individuals are often perceived as being subhuman, as not possessing the same needs, the same rights as individuals of normal intelligence.

In the past sometimes they have been managed much as animals because of the assumption that
[1-92] they did not require these human needs.

Others perceive them as a menace or potential threat to Society and hence, in the past, institutions have tended to develop as prisons with guard rails, bars, locked doors, and such as that.

Others regard retarded persons as an object of pity, to be nurtured and sheltered and consequently deprived of dignity.

Another myth is that retarded people are eternal children and hence they can be happy kept and over-protected.

Finally there is a myth that retarded persons are diseased or ill in some fashion and hence they should be hospitalized and given medical treatment.

Unfortunately, these myths, which are prevalent among the lay public, are still held by some professionals as well.

Q. Dr. Roos, we know, of course, that mentally-retarded persons reside at Pennhurst.

Do you have any knowledge as to how many retarded persons reside at institutions throughout the United States?

A. The latest data in 1976 suggest some 154,000 are residing in state-operated public facilities. There is an estimate that probably another 32,000 live in
[1-93] mental hospitals, that is hospitals for mentally-ill, and probably an equivalent number live in private institutions of various kinds.

BY THE COURT:

Q. Equivalent number to what?

A. To those in the mental hospitals — thirty-two to thirty-three thousand.

THE COURT: All right.

BY MR. THRASHER:

Q. Doctor, do you have any knowledge as to whether or not the number so residing in institutions is changing, growing, getting smaller?

A. Between 1860 and 1960 there was a marked increase. Since 1966 the rate of institutionalization has been declining according to the data compiled by the Department of Health, Education, and Welfare.

In 1966 the rate of people residing in institutions was almost 99 per 100,000. By 1970 this had decreased to 94 per 100,000; and by 1976 to 71 per 100,000.

A survey conducted in 1972 of the state institutions indicated that 72 percent of the responding institutions showed a decline in the past five years.

Q. Are you aware of the reasons for this trend.?

A. There are probably a number of reasons operating. Certainly, one is the increasing philosophy of deinstitutionalization.

[1-94] There has also been a gradual growth of alternative community resources.

Disappointment in institutions has had an impact, and finally I should mention the new technologies which have become available and which have

made it possible to habilitate and socialize, as far as individuals who, prior to the advent of the technology, were considered to be essentially hopeless.

Q. Have you made any review of the literature of mental retardation to determine how it is that such institutions have developed in this country?

A. The onset of these institutions is some time in the mid-1800s —

THE COURT: Let me just make sure I understand the question; he apparently does.

BY THE COURT:

Q. When you say the onset of these institutions, which ones?

A. The large state mental-retardation institutions, such as Pennhurst.

Q. All right. Yes.

A. The first institutions were developed in the mid-1800s essentially as habilitation facilities for the design of educating the residents and returning them to a productive life in the community. The philos-
[1-95] ophy was to make deviant people non-deviant.

Gradually, however, the philosophy changed and the institutions became sanctuaries to protect the retarded persons from Society. During this stage of their development they changed gradually into warehouses.

Sometime later the facilities became prison-like in that the main purpose was to protect Society from the retarded individuals who were perceived as potentially dangerous.

Relatively recently, well into the Twentieth Century, institutions became again habilitation facilities.

Still more recently questions were raised about the viability of institutions as effective habilitation centers. In recent years the thrust has been toward

community placement, not with regard to mental retardation but as a general social phenomenon.

BY MR. THRASHER:

Q. Doctor, you mentioned the word "habilitation" several times in your testimony.

Would you define that for the Court, please?

A. That's a generic term we use to refer to the many specific activities designed to foster maximum development of the individual. Included in the term are various approaches to education, the development of social and intellectual skills, the development of pre-vocational and vocational skills, and related types of activities.

[1-96]

Q. Are you aware in your profession, Doctor, of the results of evaluations of institutionalization of mentally-retarded persons?

A. Yes, sir.

Q. And what are they?

A. The major findings can be summarized as follows:

Generally institutions are less conducive to child-rearing than are home settings. In general, the younger the child is placed in an institution the more destructive the placement is likely to be. Likewise, the longer the placement, the more destructive it is likely to be.

The research literature has reported a number of detrimental effects of institutionalization. They include detrimental effects on cognitives, that is, intellectual development; on social and personality development, including the development of stereotyped and self-stimulating behavior on the part of the individual; in case dependency, negative attitudes toward the self, decreases in social quotient, retarded motor development, losses in IQ points, appetite reduction in language development and stunted physical growth.

Q. Doctor, you mentioned stereotypic and self-stimulating behavior, terms that will be known generally only to a person in the field. [1-97]

What does that mean?

A. These are behaviors which, to the casual observer, appear to be strange and bizarre. They are rhythmic motions, such as rocking, or head-banging or the waving of one's hands in front of one's eyes.

Other forms of self-stimulatory behavior might include certain forms of self-injury, such as picking at certain parts of the body, hitting oneself, slapping oneself, and activities of this nature.

Q. Have you, in your profession, Doctor, determined what are the causes of such behavior?

A. There has been a good deal of study as to the causes of such behavior. There is general agreement that in the majority of cases these behaviors are learned, that is, the individual has been repeatedly rewarded for engaging in this behavior. Usually they are rewarded in a subtle fashion, that is, they receive attention for performing these behaviors.

It is not surprising to find that such behaviors are found in approximately two-thirds of institutionalized mentally-retarded persons.

Q. Why do you find that not surprising?

A. One of the reasons is that such behaviors are closely associated with lack of stimulation and boredom. They tend to increase as the environment gets less stimulating. It will also increase following restraint. They are associated with hunger, with loud noise, and with strange environment. [1-98]

These behaviors, by the way, are not so unusual; they are fairly common in normal human beings. If one observes passengers waiting in an air-

port when an aircraft has been delayed for several hours one can usually observe the onset of some of these sterotypic behaviors. Individuals will start yanking at an ear or rubbing a nose or engaging in these kinds of behavior and they appear quite quickly under such conditions.

They were also observable in zoos, particularly among the higher apes — the chimpanzees and the gorillas, particularly unfortunate if they live in barren cages. One can then observe them engaging in very similar behavior to some of these retarded individuals.

Q. Would you then, in your experience, attribute some of this behavior that you have described to institutionalization?

A. Yes.

Q. Are all institutions equally good or equally bad in your experience?

A. No. There are very significant differences among institutions.

Q. What kinds of differences are you talking about?

A. The impact of the institutions varies on their efforts. There have been some comparative studies
[1-99] among institutions which suggest that in some institutions the behavior of the residents is markedly different from the behavior of residents in other institutions.

It appears that this is to a great extent a function of the amount of human contacts which the institutionalized resident has, particularly with professionals and volunteers on the living unit. The presence of educational programs and of early and intensive intervention has also been an important variable, as has the size of the institution and of the living units. In general, individuals who live on small living units and in smaller institutions show a higher level of behavior.

Q. Do you have any studies of these findings that are landmarks in the field?

A. Mark Klaber in Connecticut, as I recall, made some very interesting studies relating the level of behavior primarily to the degree of contact.

* * *

BY MR. THRASHER:

Q. Does Skadak sometimes publish under the name of Marie Christie Skadak?

A. That is correct. That is her later name, probably as a result of a marriage some time later in life.

Without going into details, these individuals studied orphans raised in an orphanage environment and studied other individuals who were raised in a somewhat impersonal manner and similar individuals who were raised by normal young women who served as mother-surrogates and they compared these individuals in later life and they found that at the end of a number of years those who had been raised by the mentally-retarded mother-surrogate had gained an average of twenty-three and a half IQ points; the other orphans who were raised in an impersonalized institutional environment had lost an average of 26.2 IQ points, an extremely significant finding.

Q. Have you determined that some institutions are more destructive than others?

[1-101] A. Without a doubt.

Q. Have you determined as to those institutions which you would characterize as to being destructive what the causes are?

A. The causes are many.

One of the prevailing ones is lack of inter-personal intimacy — the inability of the residents to model, that is, to emulate adults and to pattern their own selves after these adults.

Another characteristic of these institutions is a lack of consistent social rewards, that is, the individuals are not consistently rewarded for behaving in approved social fashion.,

Another characteristic is pervasive social and sensory deprivation. In the poor institution the environment is not stimulating.

BY THE COURT:

Q. May I interrupt to go back and take you back about two questions?

A. Yes, sir.

Q. You referred to the mother-surrogate.

A. Yes, sir.

Q. Would you explain what you mean by that?

A. Yes. I meant by that that each of the orphan children was assigned to one individual young retarded
[1-102] woman who served as if they were the mother of that particular orphan, giving that child the personal attention and consistent human contact.

Q. Was there any particular significance to the fact that the mother-surrogate was also retarded?

A. No, I don't think so. The important thing was that there was a consistent human relationship.

Q. I see.

A. Some individuals have pointed to the study as indicating that mentally-retarded women can make adequate parents; but this was not the nature of the study.

* * *

BY MR. THRASHER:

Q. Doctor, you were testifying about the destructive effects of some institutions and the causes for that.

A. Oh, yes. The problems of sensory deprivation, of living in barren, non-stimulating environment.

There is, of course a wealth of research regarding the impact of sensory deprivation on normal human beings and we know that if a normal human being is deprived even for short periods of time of sensory input the individual is likely to develop strange, bizarre behavior, including psychotic symptoms such as hallucinations, delusions, distortions of the body; in short, the kinds of behavior that are typically associated with schizophrenia.

[1-103]

There is also a great deal of research using animals, in which animals have been deprived of sensory stimulation, of sensory input; and although many species have been used, including dogs, chimps, Rhesus monkeys and others, the effects are pretty much the same in that they will show a marked deficit not only in behavior but in actual physiology.

There appear to be disturbances of deterioration, if you would, of the sensory-motor system and of the brain itself.

* * *

[1-105] BY MR. THRASHER:

Q. Doctor, your testimony is that you have stated that there is a recent trend in the treatment of mental retardation.

Will you summarize your view of the recent trend?

A. Yes. I think I can do so.

I would first refer to what we speak of as the developmental model of mental retardation. By this we mean essentially that retarded individuals should be approached with the assumption that they are capable of growth, of development, of learning; that the environment which we provide for them has a major impact in determination of the rate of this development, indeed, that the human organism is highly

[1-106]

plastic and is in continual interchange with our environment.

Specifically, we propose — "we" being myself and two colleagues who first developed this model some years ago — that environment should be designed to increase the complexity of the behavior of the developing individual to increase his capacity to cope with his total environment and to enhance its human qualities as these are defined by the world in which we live.

Since then that model has been used extensively and I understand in various national standards.

Q. In comparing the mentally-retarded person with the non-retarded person, would you characterize the mentally-retarded person as being more similar to non-retarded persons or more different than they are?

A. Well, this pretty well addresses itself to another major trend in that in the past we tended to emphasize differences and we put a great deal of emphasis on labeling and stigmatizing; in short, a generating self-fulfilling prophecy.

Recently, we have adopted a basic principle referred to as a normalization principle or principle of normalization, which is just simply to suggest that we should treat the handicapped person as much
[1-107] like the normal person as possible; that, unfortunately, we have tended to foster and generate deviancy by treating people as if they were different, by isolating them and segregating them from Society.

Q. Would you characterize that as the principle of normalization?

A. Yes.

Q. Doctor, in your experience, has normalization, as such, been applied within institutions?

A. Yes. It has been applied in a lot of institutional services, particularly by Wolfensberger. Basically,

he developed a number of concepts of typing the principles specifically to institutions. For example, he said that residential services for retarded persons should be integrated with Society in general; the services should be dispersed throughout the community so as to facilitate assimilation of the individuals.

Secondly, that residential services should be small, small and dispersed because lots of institutions, he pointed out, tend to lead to dehumanized forms of management and they form their own subculture and cause them to lose contact with a wide society.

* * *

[1-111] Q. Now, Doctor, turning more specifically to the institution which is at the issue of this case, as I recall, you had an opportunity to tour Pennhurst two separate times — once in 1975 and once in 1977; is that correct?

A. Yes, sir; that is correct.

Q. Could you summarize for the Court, if you will, please, your *modus operandi* when you took those tours?

A. Yes. I conducted a number of separate interviews with staff at all levels of the institutional hierarchy.

I reviewed —

THE COURT: May I interrupt you with one question?

BY THE COURT:

Q. When did you do this?

A. Yes, sir. April 7th and April 8th in 1975 and February 28th and March 1st in 1977.

THE COURT: Yes. You may proceed.

BY MR. THRASHER:

Q. Will you describe how you went about the survey, Doctor?

A. All right.

In addition to the subject interviews I reviewed records and various other materials and exhibits
[1-112] and I toured the facilities.

Q. Now taking you back to your first survey in April of 1975, did you determine that the institution provided all of its residents with minimally-acceptable services?

A. Yes.

Q. You did so determine?

A. I made a determination and I concluded that it did not.

Q. Did you make a similar determination at the conclusion of your second visit?

A. Yes.

Q. And what was your determination at that time?

A. That the institution did not meet these basic requirements.

Q. I presume from my familiarity with the case that you found some evidence of improvement over a two-year period; is that correct?

A. That's correct.

Q. Would you tell the Court what improvements you found?

A. Yes. I will try and summarize the major improvements which I observed.

First, I should comment on improvements in the physical environment for some of the residents. A number of the older and less-suitable buildings had been phased out at the time of my second visit and some had undergone some degree of renovation.

Q. Do you, Doctor, conclude that the improve-
[1-115] ments that you just summarized represent a major change for the residents of Pennhurst?

A. No, I would not consider it.
Q. Why is that?
A. The big problem is that large numbers of residents were still not adequately served. There was, I felt, a marked lack of program for a very significant number of Pennhurst residents.
Q. "Program" is a term you have used several times in your testimony.

What do you mean here when you use "program"?
A. By "program" I mean a formalized plan for individual training, habilitation, and treatment.

That's essentially the guideline which is to be developed, implemented, monitored and evaluated by a multi-disciplinary team, a team which includes the residents themselves and/or his parent or guardian.
Q. Do you have an idea, Doctor, as to the basic concepts that should be included in the program?
A. Yes. I would essentially consider the following the essential components of such a program?

First, a [personal] evaluation, which should include the strengths, the weaknesses, and the technical needs of the individual. [1-116]

Second, a listing of both short and long-term objectives, which again needs to be highly individualized and specific, respecting measurable and observable dimensions.

Next, specific effective procedures which are to be used to accomplish these objectives.

Ongoing monitoring regarding the progress made toward reaching the objective.

Periodic review-evaluation of the individual using objective measures of progress.

And finally, modification of the objectives and/or of the methods used to reflect the findings from the evaluation.

Now such a plan, often thought of as an individual program plan as previously mentioned, needs to be recorded, written understandably, so that it can be understood by relatively unsophisticated individuals. It needs to include the specifics and it needs to be readily available to all persons involved in the implementation.

MR. THRASHER: May I approach the witness, your Honor?

THE COURT: Yes.

BY MR. THRASHER:

[1-117] Q. Dr. Roos, I now hand you U. S. Exhibit 43, which is identified as "Standards for Residential Facilities for the Mentally Retarded, Joint Commission on Accreditation of Hospitals," and ask you if you are familiar with that document.

A. Yes, I am familiar with it.

THE COURT: What's the name of that document again?

MR. THRASHER: It is the Joint Commission Standards for Residential Facilities for Mentally Retarded, U. S. Exhibit 43.

BY MR. THRASHER:

Q. Is that the publication that you have testified about as being readily available?

A. Yes. That is the publication which encompasses the national standards of the Joint Commission.

Q. Okay.

And the ingredients of the individualized treatment program that you just testified about — will they be found in those standards similarly, as you have testified?

A. They will be delineated in this document pretty much in line with what I have just described.

* * *

[1-118] Q. . . .

Would you assign any degree of importance to these individual treatment plans?

A. I consider them essential. They are the crux of the whole habilitation effort.

Q. Why do you conclude that?

A. They are the basic blueprints for coordinating the efforts of the various individuals who are involved in habilitation.

They also are the basic evaluations too whereby one can determine the degree of effectiveness of any program.

Q. Do the present treatment plans as you envision them, Doctor, include information concerning a lot of different areas of the residents?

A. Yes. They should be comprehensive and include all areas designed to meet an individual's needs.

Q. Would the persons who would compile such treatment plans therefore come from a variety of backgrounds and expertise?

A. Typically they would. We speak of them as a multi-disciplinary team or inter-disciplinary team and they do include an expert from the various disciplines that are relevant to the particular needs of the individuals, as well as the individual himself, if at all possible, certainly, his parent or parent-surrogate.

[1-119]

Q. What disciplines would you anticipate would be required to prepare and prosecute such a plan?

A. In general, you would expect it to include a specialist in education, a specialist in psychology, a specialist in social work, plus a representative of certainly the direct-care staff who are extremely important in this effort; often, a representative of the medical profession and then various specialists, depending on the unique needs of the individual, which might include physical therapist, occupational therapist, recreational therapist — individuals of this nature.

Q. Doctor, do you conclude that the residents of Pennhurst are adequately programmed?
A. No. My conclusion is they are not.
Q. On what basis do you reach that conclusion?
A. Well, the superintendent of the institution, for example, told me that the adults at the institution receive an average of one and a half hours of programming a day.

I noticed during his deposition he testified that some 500 residents are not receiving what be considered to be minimally-acceptable care and treatment.

Q. What would you consider to be minimally-adequate programming time on a *per diem* basis?
[1-120]
A. I would say probably a minimum of six hours a day during the five weekdays and then appropriate recreation and leisure time and this type of activity on the weekend.

Referring to the standards that are being produced, one of the standards therein states specifically that activities scheduled shall not permit dead time of unscheduled activity of more than one hour continuous duration.
Q. In addition to the information given to you by the superintendent — was that Dr. Youngberg, incidentally?
A. Yes.
Q. — did you find any other evidence of a lack of adequate programming at Pennhurst?
A. The direct observation of many of the living units revealed a great deal of aimless activity, of what I call enforced idleness, people lying on the floor, milling about, sitting, staring into space, and so forth.
Q. Do you recall the wards you went on with the requisite specificity to give some examples?
A. I have made some notes on some of the specific units to which I would need to refer to do that.

Unit 47 — a lot of aimless wandering about; no observed activity. There was no staff present with ten residents in the day room. This was at 2:40 in the afternoon.

On Unit 49 — a large group of men sitting
[1-121] about or lying on the floor. It was a little after three in the afternoon.

MR. GOLDBERG: Excuse me, your Honor.

I might interrupt to say I don't know when these observations were made. There were two studies made here.

THE COURT: All right.

BY MR. THRASHER:

Q. Doctor, you are testifying now about times and wards.

Was this on your first trip or on your second trip?

A. This was on my second trip.

Q. And the dates of your second trip?

A. February 28th and March 1st.

Q. Thank you.

Would you proceed, Doctor? You were testifying, as I recall, about Unit 47.

A. Yes. I mentioned 47 and 49.

I am going over these rather quickly, if the Court pleases, to just give a sampling of the kind of observed activities.

On Unit C-9 I observed a large number of women sitting about, many of them in wheelchairs, and I observed no organized activities, which was at 3:20 in the afternoon.

On Unit M-3 men were sitting in a small day
[1-122] room; several were lying on the floor.

I asked about what programs were going on there and I was told that the only programming operation was a so-called showering program, although there was only a single shower available on the unit.

Q. How many residents lived on the unit, Doctor?
A. I'd have to look that up on the record. I don't recall.

On Unit 48 I saw a large group of men in two day rooms. I observed no interaction between staff and residents; the residents were aimlessly milling about.

On Unit K-32, which held thirty-five women, I found these women either lying on mats or sitting about.

These were the kinds of activities that were common throughout the institution.

BY THE COURT:

Q. Let me interrupt to ask you, for instance, what type of programs would you have expected to find in those particular locations that you visited?

A. Yes. Although I might later go into some of the technology, what I would expect to find is active interaction between the staff and the residents. I would expect the residents to be in small groups, working intensively with staff in specific habilitation or training activities.

This might, for example, include development of basic self-help skills, dressing skills, grooming skills.

[1-123] Then I would expect the development of some communications schedules — the staff teaching lessons how to communicate, both at the non-verbal level and then at the verbal level; the development of receptive language so they would be, for example, able to recognize objects and communicate their basic wants and needs.

I would expect some activities designed to teach residents to interact with each other in social life. In short, rather than simply warehousing the residents I would expect certain activities to be go-

ing on designed to foster the individuals' development.

* * *

BY MR. THRASHER:

Q. You testified about certain indicia in your judgment as to a lack of programming, Dr. Roos.

Did you find others?

A. Well, in addition to the direct observation I also reviewed files on specific residents and I found that
[1-124] for many of these the programmatic concept of the files was either sparse or non-existent.

In addition, I found discrepancies between what the records suggested was taking effect and what, in effect, was taking place.

Q. When you noticed these discrepancies did you note some examples?

A. Well, on A-2 I looked up the file of a specific resident.

Your Honor, do you want the number identifying these residents?

Q. An identification number will be fine.

BY THE COURT:

Q. That's a number rather than a name?

A. Yes.

Q. Yes. You may use that.

A. This was Number 6636. In reviewing the file I found no indication that there had been any development or review of programs for several months.

I also found a lack of a daily program schedule or any individual objective for this individual.

BY MR. THRASHER:

Q. Doctor, before you go on to some other examples, what would you have expected to find to indicate the input into that file that you have described?

A. I would have expected to find specific objectives
[1-125] for the individual, listing specific procedures to be

used; an indication of who was to use these procedures; and how the progress toward the objective was to be quantified.

Furthermore, I would expect to find a daily activity schedule for that individual outlining the specific activities that he was to participate in at specific times during the day.

Q. I take it, so there will be some enforceability of the program and accountability?

A. Exactly, specific outlines and specific accountability.

* * *

[1-126] Q. Do you have an example for Resident Number 8769?

A. Yes, I do. I reviewed that file on Q Building and I found that a program in "bedmaking skills" had been initiated in November of 1975 and I could find no further indication as to what had happened to the program or the individual's participation in the program.

I then asked the staff there if they could explain to me what was going on; and they were unable to describe the individual's learning program.

Looking further, I found that the latest behavior-modification program for this individual was dated October 6, 1975; the latest psychological report had been completed April 4, 1974.

Now I also noted that this was an individual who allegedly manifested aggressive behavior and attacks and there were repeated references to the use of restraints and seclusion.

[1-127] Q. Doctor, in your earlier testimony you touched on various modalities of treatment for mentally-retarded persons, one of which was behavior modification.

Would you please describe to the Court what is behavior modification?

A. Yes. Behavior modification is a very widely used technique today. It is also known as contingency management or behavior shaping.

It is essentially the systematic application of learning principles, primarily the work of B.F. Skinner, S-k-i-n-n-e-r, technically known as operant conditioning.

Essentially, it is the application of some very simple principles, namely, that behavior is strengthened when it is followed by a reward or a positive reinforcement. On the other hand, behavior is weakened when it is followed by an unpleasant consequence, technically known as a negative reinforcement.

Behavior results are weakened when it is followed by nothing. Technically, this is known as extinction of behavior.

There are many types of events which are rewarding to human beings and which can be used very successfully to develop behavior. There are usually both types of rewards that are commonly recognized.

The first of these is intrinsic rewards and this
[1-128] refers to activity which is pleasurable in and of itself; playing tennis or swimming would be examples for most individuals.

The second type of reward is the so-called social reward and that is essentially approval by another human being, which is highly potent for some individuals but not for everyone.

Artificial reward refers to such things as money to tokens. The use of tokens has been very prevalent in many institutional programs.

Then finally there are the so-called repetitive rewards which refer to those rewards which fill what are your basic biological needs, such as food and drink.

The important thing in the use of rewards is that they must be individualized and periodically evaluated because something that turns a person on today may no longer turn him on a week from now, a month from now. You may satiate a patient with a reward.

Now there are a number of basic principles in applying behavior modification which are generally recognized, which have been described in detail in the literature and unless the Court is specifically interested in these I will just indicate that they are well-established.

Q. What is the importance, Doctor — it may not be clear to everyone, but what is the relevance or im-
[1-129] portance of behavior modification to the condition of mental retardation?

A. It is probably the most effective technology available today. It is particularly useful with retarded persons because many retarded persons are non-verbal.

In the past techniques have relied primarily on spoken language, in schoolrooms, in psychotherapy, and everything else.

Many psychiatrists dealing with retarded persons do not have language. Behavior modification then is a technique which is particularly successful with non-verbal individuals. It is a sympathetic technique which can also, therefore, be applied by individuals who are relatively untrained — direct-care staff, parents, and other individuals under the proper supervision and guidance can apply these techniques.

The techniques are applicable to individuals, but they can also be applied to groups of individuals with relative ease.

Q. I take it from your earlier testimony that the condition of mental retardation itself is primarily identified by the aberrant behavior of persons as opposed to those exhibiting normal behavior?

A. No, I would not say that.
Q. How would you describe then behavior fits into the definition of mental retardation?
[1-130] A. I would say that the basic problem, of course, is in the area of learning; that most retarded persons will not manifest aberrant behavior, but rather will manifest deficits in behavior, a lack of skills, a difficulty in acquiring skills or taking longer to acquire skills.

The aberrant aspects of behavior seem to be a part of the environment in things which are learned in it and are not learned in the inherent aspects of mental retardation.
Q. Would you define [behavior] modification psychiatry such as you have described in Pennhurst?
A. I did find such techniques in use on a number of the units. I was surprised, however, to find that they had been abandoned on a number of units.

Specifically, for example, on M-3, where a token economy is in operation, I was told that it had been abandoned some two years ago and that no substitute program had been instituted.

I also found on Unit Q-1 that a token economy had been abandoned allegedly because of the staff's inability to obtain proper reinforcers, that is, they couldn't obtain the proper kind of things to reward the residents on this unit. I found this was particularly unfortunate because this unit was supposed to have an expensive habilitation unit designed specifically for individuals who are manifesting aberrant forms of behavior.
[1-131] Q. Did you determine why, in your opinion, the procedures that you have described at Pennhurst were not effective?
A. Well, it was apparent to me that in some of the units the staff, the direct-care staff themselves, seemed unfamiliar with the procedures or not properly motivated to use them.

I also found that an intensive training unit, such as Q-1 is supposed to be, which was designed to apply the technology intensively to residents so that they could be returned to their basic living units, was not having that effect and that, indeed, there was very little turnover on that unit, so that residents stayed there literally for years.

So that —

Q. Excuse me. Did I interrupt you, Doctor?

A. I was just going to say so that the unit was really no longer an intense habilitation unit. It just became a dead end appparently.

Q. Okay.

Would you describe Unit Q-1 as compared to the units that such persons would have returned to had it been effective?

In other words, was it more restrictive than the other wards?

A. I am told it was more restrictive than the other wards and less stimulating in general.

[1-132] Q. How was it more restrictive?

A. It was a very barren place. There is a place called the day room with no furniture in it at all; just bare floor and bare wall.

I think that there was one basketball baskethoop upon the wall.

Then, as I recall, there was a sort of a large bedroom area in which the beds were just sitting one right next to the other. I don't recall seeing any curtains or drapes or decorations other than some painting on the walls themselves.

There is also a seclusion room in that unit.

Q. Would you describe what a seclusion room is, Doctor?

A. Well, of course, seclusion rooms differ considerably. This particular room was a fairly large room with a very high ceiling.

It was dark in there, as I recall. A heavy door with a little opening in the door and at the top of the room, near the ceiling, there were some pipes. I assume they carry water, steam, or some such thing.

Q. Were the walls and floors padded or where they hard?

A. I don't recall any padding. This was all hard.

BY THE COURT:

Q. What do you mean by a seclusion room?

A. Essentially by "seclusion room" I mean a room
[1-133] where an individual is kept by himself with the door closed and he is kept there, segregated from the rest of the living space, for a period of time.

BY MR. THRASHER:

Q. Did you find that Q-1 was a locked ward?

A. As I recall, it was.

Q. That is, the residents aren't free to leave the ward?

A. Yes.

Q. You mentioned seclusion, Doctor.

Did you find at Pennhurst the use of restraints and seclusion?

A. Yes. I found both were common.

Q. Do you recall any example that you saw on your tour? I take it this is the most recent tour in 1977?

A. Yes.

Q. Will you give some examples, please?

A. On Unit H-2, I noticed Resident 6636. The record indicated that seclusion was used with this individual on a PRN basis, which means as needed, apparently during twelve-hour periods.

In addition, this individual was in restraint and was receiving heavy medication.

On Q-1, I have already referred to the seclusion room there. I found that Case Number 8769 showed frequently placement in seclusion.

[1-134] I did visit that particular seclusion room and I found feces on the ceiling of that room and a bunch of old clothing hanging on those pipes which I have described near the ceiling of that room.

I was told by the staff that this room was cleaned every other day.

I noticed from the superintendent's deposition that there are five or six seclusion rooms scattered throughout the institution.

Q. Doctor, you mentioned PRN.

In your experience what is the purpose of PRN orders?

A. Well, when you get to seclusion, this is essentially the direct-care-staff, an open door putting the individual in the seclusion room at any time they see fit.

Q. Did you see any other examples of restraint?

A. Yes. I saw quite a few restraints in use. In Q-1, Case 8769, there was a leather band. The hands were being pinioned in this fashion.

Case 9001, likewise in these bands. On Ward 1 of the hospital, an individual tied by both wrists to a wheelchair. I saw several tied in their bed, either by the wrists or by the ankles.

On Unit C-9, an individual was tied in bed by the wrists and the ankles both.

[1-135] On Unit H-2 I saw an individual in leather muffs.

These are some of the specific instances which I made a record of.

Q. In viewing the use of seclusion and restraints as you described, what do you conclude as concerns Pennhurst?

A. It suggests to me first that it is simply improper and/or inadequate programming. These are symptomatic of individuals just not receiving the services they need.

In addition, of course, I considered the use of such techniques as highly dehumanizing. One of the real problems when you incapacitate individuals is that this precludes their learning and hence precludes their development. You are essentially condemning the individual to a lifetime of confinement.

Furthermore, evidence suggests that the use of this technique tends to increase the tendency toward self-stimulation, self-destructiveness, stereotomy, and other behaviors. That is the very cause of the behavior which it is designed to eliminate.

Q. Doctor, in your opinion do you feel that seclusion is acceptable?

A. Well, the standards here, the blue book, say there specifically that seclusion defined as the placement of a resident alone in a locked room shall not be employed. That is categorically stated there — should not be, shall not be.

Now I feel that generally this is correct. I would make one exception, and that is the use of a technique known as seclusion time out, which is a very specific technique incorporated in a total regime of behavior modification.

I can see it as acceptable under specific conditions.

Q. Did you find those conditions extant as to Pennhurst?

A. No, no, I didn't.

Q. Did you find indications that residents had been placed in seclusion, that is, in a solitary room with a locked door, for a period of time?

A. Yes.

Q. Do you recall approximately how long periods of time?

A. As I recall from looking at various records, some

individuals were placed in seclusion for many hours over a period of years.

Q. Do you find that an acceptable habilitative treatment?

A. I find it totally unacceptable.

* * *

[1-139] BY MR. THRASHER:

Q. Doctor, we were covering the practice of seclusion and I believe I had asked you whether or not seclusion was an acceptable practice and you had defined it as a practice of seclusion which was very limited in form.

Now that was in regard to the way of addressing certain behavior. What do you consider to be effective and acceptable procedures for addressing a hypothetical question and eliminating undesirable behavior patterns of mentally-retarded persons?

A. Beginning with the basic assumption of undesirable behavior alone and untainted by the environment, obviously, the first approach to eliminating them is to minimize those factors which cause such behavior in the first place, that is, boredom, inactivity, frustration, harassment, and so forth.

[1-140] In addition, now, specific techniques are designed to weaken undesirable response. A number of these consist primarily of systematically rewarding desirable behavior and ignoring undesirable behavior.

To implement these techniques requires the coordination of all individuals interacting with the client so that consistency is maintained.

If one individual rewards an undesirable behavior this would immediately and consequently undermine the total program.

In addition, specific techniques have been developed, particularly by Nat Agrin, A-g-r-i-n, which

are designed to deal effectively with particularly noxious behaviors which cannot be simply ignored.

An example of this is what we call the technique of contingent observation. Let me use it as an example of design.

Assume for a moment that there are several persons engaged in a training activity and then one of these individuals becomes highly destructive. He will then be removed quietly from the group and asked to sit in a chair and asked to observe what the other individuals are doing for a relatively brief period of time.

When he has quieted down and has regained
[1-141] attention he is then returned to the group.

An analogy to this is the people-block game, when an individual is put in the box and asked to observe the game on a contingent basis.

* * *

[1-143] BY MR. THRASHER:

Q. Dr. Roos, did you find that the procedures to address destructive behavior were effectively employed at Pennhurst?

A. No. I felt they were not.

One of the basic problems is that the environment itself is in many cases not rewarding, not reinforcing; so that being drawn from it may, in point of fact, be perceived as a reward rather than the taking away of a reward.

The lack of activity, the lack of systematic program, makes it very difficult to apply these techniques effectively.

Indeed, it is quite probable that the situation frequently strengthens negative behaviors because they are the behaviors which tend to get the attention of the staff.

Q. Did you find an adequate monitoring system on such procedures at Pennhurst?
A. Generally, I found there were no adequate monitoring procedures.
Q. Are there standards available —
[1-144] A. Yes.
Q. — to establish guidelines for such monitoring?
A. Yes. There are effective techniques, specific guidelines have been developed both by the American Association of Mental Deficiency and our own association has published guidelines specific to the monitoring of behavior-modification programs.

These guidelines require review, ongoing review by a professional review committee as well as by the Human Rights Review Committee.
Q. Do you feel that Pennhurst has adequate monitoring methods?
A. Unfortunately, I feel this is one of the areas in which the institution has made only slight progress, very little progress, during the few years.
Q. Do you have in mind some examples that were lacking in this regard at Pennhurst?
A. The superintendent told me at the time of my second visit that there was no formal statement on the residents' discipline. He indicated that a policy on abuse was not yet operational, that it was not yet — it was being evaluated and he, himself, felt it was too lenient because it defined three degrees of abuse.
Q. Let me interrupt you there.

What is a policy on abuse? What does that mean?
[1-145] A. In terms of his description of it I would assume what he was referring to was a policy which he would push with regard to employee abuse of residents.

[1-146] Q. Did you determine whether or not, Doctor, there were any what the Commonwealth referred to as advocacy programs?

A. No. Again, at the time of my first visit there was discussion of the institution's attempt to develop an advocacy program.

By the time of my second visit, little or no progress had been made. I was told by the superintendent that there were only three to five residents involved in such a program and the superintendent said himself that the program is very, very limited.

Q. And what is the advocacy program?

A. The program that we were discussing is essentially a citizen-advocacy type of program in which interested citizens volunteer to serve on a one-to-one basis in relating to a protege, that is, an individual mentally-retarded person; and third that that individual stands as a father-advocate and looks after the individual's human rights as well as emotional needs.

THE COURT: May I just interrupt there and ask a question?

[1-147] BY THE COURT:

Q. This was along the line of the grandparents program that you said the Federal Government was sponsoring?

A. It is to some extent. Both programs give some emotional support to the residents.

Q. I was going to ask you at that time, but I will ask you now — in connection with Pennhurst, why could not the patients' own relatives serve in that capacity?

Of course, I recognize that there may be some that don't have relatives that are interested, but in view of the statement made this morning, which is certainly not true for all of them — now why couldn't that be included? Why wouldn't that be a

more effective recommendation that the child's of the person's own parents or close relatives assume this role and work with him?

A. That certainly is a logal approach, your Honor. A number of problems, nonetheless, occur.

First, that many residents no longer have parents; second, and it is difficult for me to say this, but to some degree parents are often reluctant to antagonize the institution. They fear, whether this is rational or not, possible retribution by the institution's staff against the child.

Having been a superintendent myself, as well as the parent of a child in an institution, I realize
[1-148] that this factor, unfortunately, is still present in some cases.

The third problem is that there may be some cases in which the parent may not be the best advocate for his own child. There may be some cases in which the interests of the parent and the interests of the child may not coincide. Hopefully, that would be infrequent but, nonetheless, it will sometimes occur.

[1-148] BY MR. THRASHER:

Q. Dr. Roos, in regard to the Judge's question and your answer, would the geographical and physical location of Pennhurst pose any problems to parents acting in the manner you just described?

A. I would suspect that the geographic distance between some of the parents and the institution would be a logistical problem.

Q. Are there other areas, Dr. Roos, in your judgment, where Pennhurst has failed to make adequate progress in the last few years?

A. Yes, definitely.

Q. Will you give us some examples, please?

A. The institution has frequent conditions which violate what you might call human dignity and respect for the individuals.

We discussed some of them and without delinating them into detail, let me mention just
[1-149] things as dehumanizing environment; toilets without doors, without partitions; toilets without toilet paper; sometimes without tile toilets; sometimes unflushed, dirty, filthy; open showers; lack of soap or towels; lack of decorations; lack of any individualization in the living area; lack of pillows on the beds — little things like that.

Residents are being forced to eat either with their fingers or with spoons with no other kind of eating utensils. Urine on the floor, feces on the ceiling — these kinds of conditions.

Indeed, in looking at the superintendent's deposition I noted that he indicated that he felt the environment did not meet minimum professional standards; and I would certainly concur in this.

Other considerations — the clothing for many of the residents is ill-fitting. It is obviously institutional in nature.

On a number of units I found residents in partial states of nudity. On some they had no shoes — bare feet — and things of this kind.

A lack of privacy is general throughout the institution. In many areas they sleep in open sleeping areas, no drapes or curtains on the windows, no quiet place where an individual can withdraw for a certain period of loneliness; usually large groupings, frequently loud music, and all blaring
[1-150] television sets; lack of provisions for any personal property.

These kinds of conditions are characteristic.

Q. Would you describe the conditions that you just testified about as creating a home-like environment?

A. Quite the opposite. They are unlike any home. Even the rhythm of life is often at a marked deviance from what we experience.

I was shocked to find, for example, on one living unit that the individuals eat supper at four-thirty in the afternoon and that the nurse from the unit spontaneously commented that the residents get extremely hungry and they are disturbed as a result of this schedule.

These people are put to bed at nine-thirty and the entire rhythm of the day is at variance with the normal.

Q. Is that done for adults?

A. Yes, this was an adult group.

Q. Do you have any opinion, Dr. Roos, as to the impact such conditions and environment would have on mentally-retarded residents?

A. I feel that the impact would be highly detrimental to these individuals. Obviously, these conditions violate the basic principles which I mentioned this morning. They foster deviancy. They violate our
[1-151] concept of normalization and developmental programming.

Indeed, these conditions are likely to cause regression and deterioration rather than development — deterioration both psychologically and physically. They are liable to foster pathological behaviors of all types and I will outline some of these.

It certainly violates attempts at individualization. Regimentation prevails and many of these people are robbed of their individuality.

And when it comes to self-actualization the type of environment and conditions I have described tend to foster compliance and eliminate the possibility of decision-making.

Q. Doctor, you mentioned regressing.

Could you tell the Court what that means?

A. By regressing we mean essentially the behavior becomes increasingly more primitive, that is, more childlike, less mature, less sophisticated.

* * *

BY THE COURT:

Q. How many residents were there at this time when you were visiting, if you know, when the staff was 1,560?

A. As I recall, at one time that I visited there were somewhere over 1200 residents.

Q. 1200 residents?

A. . . .

[1-153] Now, in addition, and I am particularly concerned about this, there seems to be a decrease in the number of professional positions.

BY MR. THRASHER:

Q. Would you define professional positions, Doctor?

A. We are talking essentially about educators, social workers, psychologists, physicians — people of this nature.

What seems to be happening is that as a professional person leaves the staff that position is changed into a direct care position and instead of being able to recruit a like professional the institution is able to recruit a direct-care staff person.

The result of this is that the professional services division has lost nineteen professional positions in the last two years. For example, psychologists have decreased from twenty-three to nineteen and the persons in the development of program tech-

[1-154] niques have decreased from seventeen to thirteen and so on.

One of the things that's obvious, as you look at the situation, is that there are long waiting lists within the institution of residents being referred to specific services by the program team, but not being received by these services because of lack of staff.

Q. Does that mean, Doctor, that you described a group of residents who are already admitted to Pennhurst and whose needs have been defined at

Pennhurst and whose needs even as so defined Pennhurst cannot meet?

A. That's exactly the case, yes.

Q. Did you, in your tour of Pennhurst in 1977, observe any areas or wards where there were not staff present?

A. I made note of one particular group, housing for profoundly-retarded individuals, where there were no staff present at the time of my visit here.

* * *

[1-155] Q. Do you know of any impact on the residents of the buildings from the staff?

A. Yes. There tends to be a lack of coordination and effort to erase any gap between the plans as reflected on paper and the implementation of these plans when you observe what is actually taking place on the living units.

Q. Okay.

Are the attitudes and roles that the staff assume vis-a-vis mentally-retarded residents important?

A. Extremely important.

Q. What roles should staff members play as com-

[1-156] pared to their services to mentally-retarded residents?

A. It depends, of course, on the particular staff. The main care of the direct-care staff is with the residents many hours a day. Traditionally, these individuals tend to consider themselves as custodians and house custodians.

The feeling today is that they should essentially be trainers, socializers, and that they need to make a shift if they are truly to be helpful for the residents.

* * *

[1-158] BY MR. THRASHER:

Q. Now, Doctor, the conditions that you have testified about at Pennhurst, do you feel what you observed was essentially hazardous to the residents?

A. Yes. I feel the conditions are potentially hazardous psychologically.

Q. Could you give us some specific examples, please?

A. Being brief, if I may, your Honor, I would emphasize these situations:

First, filth. I observed excrement, urine, dirt, mops strewn about, pools of water on the floor, piles of clothing scattered about, and things of that nature.

Secondly, the toilet areas. Particularly disturbing is an almost universal lack of toilet paper on the units which I observed; no towels, no soap, unflushed toilets, toilets without seats — conditions which violate the very basic principles of hygiene.

Third, I was impressed by injuries suffered by the residents. On my tour I observed some of these injuries — a bleeding gash over the eye of one residents, bad patches on the leg of a woman.

In reviewing the superintendent's deposition I noticed that he reported 833 minor injuries and 25 major injuries during the month of January 1977. That's during a single month.

[1-159] As I indicated too, there seems to be a lack of supervision. In some of the units there may be very few or in some instances no staff present.

Feeding practices — I felt they were at times quite tenable.

MR. GOLDBERG: Your Honor, this seems to be rather repetitive. This has already been stated by the witness in his previous testimony.

THE COURT: This is the first time I have heard this.

BY THE COURT:

Q. You may proceed.

A. Well, I think that the feeding practices — I did observe, for example, in one dining area, an attendant feeding a resident much too rapidly, shoving

food into that resident's mouth, which, of course, has some potential danger of implications for that resident.

BY MR. THRASHER:

Q. Is that manner of feeding particularly dangerous in a mentally-retarded population?

A. There is an added danger in the retarded population, particularly individuals who are severely and profoundly retarded. There is a danger of pneumonia, there is a danger of lack of nourishment, and the individuals may not be able to indicate that they are being fed too rapidly.

* * *

[1-160] BY THE COURT:

Q. Let me ask you a question, Doctor,

In your summary of the conditions just how that you mentioned as having been in your opinion, or I will put it this way, conditions that are hazardous to the residents, I think the last one you referred to was the feeding practices.

Do you have any information that you obtained from Pennhurst as to how many of the residents have to be fed by hand in the instance that you just described?

[1-161] A. I do not your Honor. I think the data are available but I do not recall seeing them myself.

Q. Generally, let me ask you this as an expert — in an institution that is housing retarded persons, what percentage of them would you expect to find that required individual feeding?

A. It would depend on basically two variables — one, the level of the retardation of these individuals. I would generally expect that very young individuals would need such help; seriously ill individuals during the period of the illness, or profoundly-retarded individuals.

Now the second variable is the amount of training.

We know that even profoundly retarded individuals seem to feed themselves unless there is a neurological or motor problem.

Q. Would one conclude from what you have just stated that the problem of feeding by hand a resident would be a very small percentage of the population then?

A. I would say that's very correct, your Honor, if training programs are in operation.

* * *

[1-162] BY MR. THRASHER:

Q. Dr. Roos, I draw your attention to U. S. Exhibit 15. As you have heard, undoubtedly, there is no reason for the names of persons to be used in the testimony if you see them through the ink.

I ask you if you have had opportunities to review that exhibit in the past.

A. Yes.

Q. Would you describe what it is?

[1-163] A. It is a cumulative accident summary. It is dated 12-29-76 to 1-29-77.

Q. What does that show?

A. It shows a long list of accidents.

Q. Could you give some examples?

A. Well, she had an injury on the forehead, fractured finger, laceration on the left side of forehead, three sutures; laceration of occipital area, four sutures, and so on down the line; broken foot, lacerated head.

Q. Do you draw any conclusions from that information.?

A. The thing looks a little like a battlefield report. It appears that it is physically hazardous for the residents to be in the environment.

Q. I call your attention, Dr. Roos, to U. S. Exhibit 16. Can you find that, sir?
A. Yes.
Q. I ask you if you have had an opportunity to review that exhibit?
A. Yes.
Q. Can you describe to the Court what the document is, please?
A. Well, it is a request for the erection of a protective fence.
Q. What's the name of the department?
A. There are several of these. The one I am looking
[1-164] at is the July 16, 1974. Then there is one July 30, 1974; February 14, 1975; February 27, 1975; and March 4th of 1975.
Q. Is there a memorandum in that exhibit which indicates the reason for the events?
A. Yes, individuals drowning in the river there near the institution, the Schuylkill River, and it lists here some nine individuals who have drowned and the memos are all designed to obtain permission to erect this fence.
Q. Now, Doctor, directing your attention to U. S. Exhibit 15, I ask you if you have had an opportunity to review that exhibit at any time?
A. Okay. Yes, I did.
Q. Will you describe to the Court generally what is in that exhibit, sir?
A. Well, very briefly, this is an accident — a special report of a situation in which one resident bit off three-quarters of the ear of another resident.
Q. When was that? When did that happen?
A. Oh, it was in January 1975; and interestingly enough the unit director's summation and recommendation strikes me because the unit director stated accident came about due to staff's having to concentrate their attention on one resident who required first-aid.

[1-165] As long as only two or even one aide is expected to provide care and supervision of residents plus custodial functions, this type of accident is unavoidable.

Q. Is there a date on that memorandum, Doctor?

A. That memorandum is dated January 8, 1975.

Q. Dr. Roos, I now hand you some stacks from U.S. Exhibit 18, Volumes 1 and 2, and ask you if you have had an opportunity to review those documents in the past.

A. Yes, I have. I have seen them.

Q. Could you tell the Court what those documents are, please?

A. Okay. The first one is a situation in which a resident slipped out of the grip of staff, or a staff person, fell on the floor, fracturing the right humerus; and a broken arm resulted, of course.

Q. Do you have any others?

A. This second one is a situation which an individual was in a wheelchair not his own, and he said there were no safety devices and the individual drug his feet, fell out of the chair, sustained laceration over the left eye and, in addition to that, a broken arm.

This was not found until twenty-four hours after the event had occurred.

Q. Now are there three other reports there?

A. Yes, there are several more.

This one — an individual slipped and broke an arm.

[1-166] I am going over these rather quickly. This is one about an individual — another fracture before and the comment of this individual is staff person says events leading to accident were all a part of daily routine. Given this accident of this nature seems unavoidable, sometimes overnight.

Q. Is that the report where the person involved was requested to pick up a table and move it?

A. Yes, yes. This individual was asked to pick up a table, stumbled under the weight of the table, and fell under another table and sustained a fracture as a result.

Q. Are there two more reports there, Doctor?

A. Yes.

All right. This is a report of an individual who was in muffs, that is, in hand restraint, and who fell as a result of that and sustained lacerations, sutures, various other stress; and the unit director stated it is my own personal opinion that putting residents in muffs is a dangerous practice. I have asked the nurses to talk to the doctor about putting residents in muffs.

There may be a little problem reading this. Anyhow, it says no results thus far. Can this matter be brought before the Safety Committee to determine alternative methods of proceeding?

[1-167] And I don't have a muff, and this was dated October 24, 1975.

Then there is the last one here. This is an individual who was placed in seclusion and who kicked the window in the seclusion room in and he sustained lacerations and contusions over various parts of the body as a result.

Q. Doctor, Exhibit 3 should be over there next to your report.

I ask you if you have had an opportunity to review that exhibit at any time.

A. Yes.

Q. Would you describe, please, what that exhibit contains?

A. Well, without going into details, this situation here is a special report dated October 6, 1976 and it has essentially an eyewitness account of a staff person raping a female resident.

Q. That is October 1976?

A. That's correct.

[1-168] Q. I now direct your attention to U.S. Exhibit 26, Doctor, and ask you again if you have had an opportunity to review that exhibit.
A. Yes.
Q. Would you tell the Court what that is about?
A. This is a situation in which an attendant beat a female resident with a shackle belt.
Q. I now direct your attention to U.S. Exhibit 37 and ask you again if you got an opportunity to review that exhibit.
A. Wait a minute. Okay.
Q. Did you find it?
A. I believe I have it. Okay.
This is a description of an attendant beating a resident with a set of keys.
Q. And what is the date of that report?
A. The first date on this is Spetember 7, 1976.
Q. Doctor, after reviewing Pennhurst and the exhibits as you have testified, are you satisfied that the interests and the welfare of the residents of Pennhurst are adequately protected?
A. No. I feel that they are not.

* * *

[1-169] Q. What pictures are those?
A. 47, 48 and 49.
Q. Now, Dr. Roos, in U.S. Exhibit 48, the picture book which is now before you, I direct your attention to Picture Number 47 and ask you if you recognize that?
A. I am sorry. Say again the number, please.
Q. 46?
A. 46, yes, I see that.
Q. Did I give you the wrong number?
A. That's all right. I recognize it.
Q. Will you describe that to the Court, please.
A. That is a bathing area and there are three men in wheelchairs, a radiator and a number of open toi-

lets; and as can be readily noted there is no type of privacy whatsoever.

Q. Would you point out to the Court what things, if any, you see to be antihabilitative or not meeting
[1-170] professional standards?

A. Well, it seems pretty obvious — I think the Court can see this — that there is absolutely no possibility for anything resembling privacy. That's a totally drab, impersonalized kind of environment.

In addition, there is some dirt lying around there and a bunch of wheelchairs sitting in the bathing area.

Q. Now I direct your attention to Photograph Number 50.

A. Yes. That's a black-and-white photograph, unfortunately, I believe, but the materials on that toilet seat are feces and there are also feces on the wall and the floor.

Q. Are they indicative of some of the conditions that you have testified about?

A. Yes.

MR. GOLDBERG: Your Honor, there is no date on any of these photographs.

Were these photographs all taken at the same time?

MR. THRASHER: Some of them were taken in 1975 and some of them in 1976.

MR. FERLEGER: For the record, I note that the table of contents, at least with my set of photographs, does list various dates.

MR. THRASHER: They are arranged in the table of contents by our expert witness, you Honor.

[1-171] THE COURT: Yes.

MR. GOLDBERG: Thank you.

BY MR. THRASHER:

Q. Dr. Roos, I direct your attention to Picture Number 54 and ask if that is an accurate representation of some of the conditions that you saw at Pennhurst.

A. Yes.
Q. Would you comment upon what that picture shows to the Court, please?
A. That is a day room, which you will notice had no furniture, no drapes; just the bare floor and walls, and that is a resident almost nude lying on the bare floor.
Q. I direct your attention now, Dr. Roos, to Picture Number 56.

You have testified earlier about residents wandering aimlessly about, and I ask you if that is an accurate representation of what you observed.
A. Yes. That's a photograph of a typical scene in the so-called day room.

If this was a moving picture rather than a still picture you would notice that many of these individuals are referring to the aeroclothinic behavior that I referred to earlier.
Q. What do you mean by that?
A. You will find that some of these individuals are rocking back and forth. Others are waving their hands in front of their heads, in a rhythmic and non-purposeful manner.

Most of these are either milling about aimlessly or engaging in these types of behavior.
Q. Now, Doctor, I direct your attention in the same exhibit to Picture Number 52.

Do you recall your testimony earlier about woman lying on mats doing nothing; and I ask you if that picture is an accurate representation of what you were testifying to.
A. Yes, that is a picture of that situation.
Q. Would you comment to the Court, please, as to what you would conclude as a professional in the field as to the caliber of the programming and habilitative activity?

A. There is no activity taking place there. This is what I described as enforced idleness.

These individuals are simply vegetating there and there seems to be no systematic activity.

Q. Doctor, I believe you have testified extensively about the dangerous conditions and the impact on residents at Pennhurst.

Are there other matters in this regard that you have similarly characterized, such as overpopulation?

A. Yes, sir, I would. I think it is fairly obvious that many of the residents at Pennhurst are living in to-

[1-173] tally unsuitable buildings, in large groupings, with lack of privacy and with obstacles to programming and development.

I notice that the superintendent in his deposition indicated that he felt between 475 and 500 residents were living in buildings which should be vacated on the basis of the Joint Commission's survey which was conducted by the institution some years ago.

There have been serious delays in remodeling and in construction as well as of the so-called new modular homes; and as a result these individuals, many of them, are still living in totally intolerable conditions.

Q. Dr. Roos, do you recall the ratio in the population between your first visit in 1975 and your second visit some two years later?

A. Yes. The superintendent informed me that the population had increased by approximately 150 during that two-year period.

Q. Was that consistent with your observation?

A. Yes. That seems to be generally in line with what I observed, as well as with the records which I saw.

* * *

[1-177] Have you reached some major conclusions concerning Pennhurst?

A. Yes, I have.

Q. Could you summarize those thoroughly for the Court, please?

A. Yes. I will be very brief. I have reached the following conclusions:

First, a significant number of residents at Pennhurst is not receiving minimally adequate treatment. Their most basic developmental needs are not being met.

Second, the conditions at Pennhurst for many are likely to foster regression, maladaptive behavior, and curtailment of mental, personal, social, and physical development.

Among these conditions I would emphasize enforced idleness, mass living and regimentation, an environment which deviates markedly from the normative.

My third major conclusion is that the physical
[1-178] plant is not well suited to developmental programming nor to normalization. The management cluster and practices are often counterproductive and work against improving services to the residents.

Thus, I feel that there exists a major discrepancy between the written documents of the institution, many of which are excellent, and observed practices. There is many times a failure of implementation, so that much of the philosophy has minimal impact on many of the residents.

Finally, I would conclude that many of the residents could be better served in less restrictive settings, using less drastic intervention and more normative approach.

Q. Doctor, I know that you have prepared some recommendations based upon your opinions and your views of Pennhurst. Some of those, I think, during your testimony were either covered fully or in part.

I would now ask for you to summarize what major remedial recommendations you might have for the Court in this area, focusing on those primarily which you have not yet testified about, if you have any.

A. I would recommend first that each and every resident of the facility receive comprehensive developmental individualized programming designed to increase the complexity of his behavior, help him to cope with his environment, and develop human qualities that he —

[1-179] I have outlined in some detail what I consider to be adequate programming and I think it might be redundant to go over these specific recommendations at this time.

Second, I feel that provisions should be made to assure that every resident has the least restrictive environment possible and the greatest possible freedom of choice — choice in dress, grooming, movements, use of free time, contact with the community, and so forth.

The staff, I feel, should prepare residents to move to more direct community living, from larger to smaller facilities, larger to small living units, from groups to individual residents, segregated facilities to facilities integrated in the community, and from dependent to independent living.

Fourth, the living conditions should be designed to approximate normative patterns to the greatest extent possible. This would include maximum grouping of no more than eight residents, privacy, personal property, storage space, and such like.

Clothing that is normative, grouping that is normative, attractive and comfortable living facilities, which are air-conditioned, with rugs, drapes, stuffed furniture, and so forth.

[1-180] Accessible toilets with toilet paper, towels, soap, partitions; adequate showers, a rhythm of life which approximates the normative patterns of living.

Access to such appropriate toys and equipment, normative eating patterns, restriction to canceled and improved and as much freedom of movement as is possible.

Next, I would suggest procedures should be established and implemented to protect all residents from abusive and dangerous practices. This would include a direct review with an opportunity for appeal to a human rights advocacy committee.

Due process procedures regarding the use of the behavior modification program, seclusion time-outs, and restraint.

The establishment of an ombudsman at the institution; and finally, the use of exit interviewers with staff on leaving the institution.

Q. Doctor, are you recommending procedures to guard against abuse or behavior modification, seculsion, and restraints differently than what you have already described or are they the same?

A. They are essentially the same, but I am suggesting the desirability of a professional advisor group and of a viable, truly independent human rights advocacy committee so that these two bodies can participate in the review and appeal proceedings.

[1-181] Q. Would you have any recommendations concerning the record-keeping procedures?

A. There are specific requirements and record-keeping relative to behavior-modification procedures. I think they have been well outlined by the Manual on Mental Deficiency, as well as our own guidelines and I would feel confident if these are implemented.

Q. Would you recommend any reorganization in the concept as used at Pennhurst of the units and departments of dual authority?

A. Yes. I feel that the effectiveness and the efficiency of the staff can be significantly enhanced by eliminating the confusion which now exists in terms of team leaders having a dual reporting responsibility.

I also suggest the establishment of a training and demonstration unit for the in-service training of staff.

Q. What would be your policy concerning admissions?

A. I would continue what I assume is currently a moratorium on all admissions.

Q. Would you have any recommendations in this area concerning the population level at Pennhurst?

A. I think that there needs to be deescalated population, drastically, to greatly decrease the density of the population, to integrate the greatest possible number into the community, and to establish a cli-
[1-182] mate in which the basic principles as outlined can be implemented.

I know that there is a proposal to reduce population to around a thousand residents and I feel that is much too large.

Q. Doctor, I presume that for a major deescalation of population there would be a requirement for planning mainly and that it be properly planned and followed.

A. Yes.

Q. Do you have any recommendations in that regard?

A. Very briefly, yes.

Obviously, there is a need for a systematic deescalation plan with long and short-term objectives, including specific numbers, specific time lines, and

a system for program evaluation and review, and this plan must be a systematic plan for vacating specific buildings.

The greatest possible number of individuals must be systematically prepared for community residence. Suitable candidates must be identified on an ongoing basis by the program teams. Residents and their parents or guardians must be involved in this individual planning, including the selection of the most suitable community alternatives.

It is essential that community resources be developed in concert with this overall plan, with adequate budget, advocacy, monitoring, and evaluation
[1-183] of these community alternatives.

As part of this plan I would suggest the establishment of a form of advocacy program.

Q. Doctor, what service is there now provided at Pennhurst that could not be provided in this community?

A. I know of none.

Q. Assuming, Doctor, that services were available in the community, what percentage of Pennhurst residents could be appropriately served in the community?

A. I'd say a hundred percent.

Q. Do you have any recommendations for a monitoring system or an accountability system to oversee such a movement from a major institution to communities?

A. Yes. I would forcefully urge the establishment of a review panel, a panel charged with implementation of the Court's decision, directly responsible to the Court, required to submit periodic commitment reports, possibly every sixty or ninety days, making periodic revision recommendations to the defendants, including specific timetables for implementation.

Such a pattern should have direct access to all information, should be able to visit the institution and to interview.

* * *

[BY THE COURT:]

* * *

[1-185] Did you find anyone among the professional staff during your visits of 1975 and 1977 who, in your opinion, you considered disagreed with any of those recommendations?

A. I don't really think so, your Honor.

I think the major area of disagreement, if there be such an area, is the matter of timing, the time line.

I think there is general agreement on philosophy, on objectives, and on goals.

Q. That question of mine assumed that you must have discussed some of these things —

A. Yes.

Q. — while you were visiting the staff.

A. Quite so.

I think one of the problems we would run across, your Honor, is that there seems to be good agreement on basic philosophy and objectives. The basic problem is one of implementation.

Q. When you say the basic problem is one of implementation, if those that are administering the program at Pennhurst agree with you and your recommendations, tell the Court why they are not being carried out.

A. Part of the problem is the bureaucracy within which the staff has to operate.

Q. When you say the bureaucracy in which they
[1-186] have to operate, are you talking about the bureau-

cracy that is present at Pennhurst or are you talking about the general bureaucracy that is present in all government, including the State government and the Federal government?

Just specifically, what do you mean by that?

A. All right. I am talking about some of both.

Q. I didn't mean to leave out the City over there.

MR. THRASHER: Surely not the Federal government.

THE COURT: All right.

THE WITNESS: I think we are talking about some of both.

I think some reorganization within the institution would help matters and I felt specifically about the problems of classifying individuals, reducing the span of control, and clarifying the lines of administration of some of the key program people. Some of that could be done, I expect within the institution.

Part of the problem, however, is the State bureaucracy, which greatly limits the amount of flexibility which the institutional administrator has in these areas.

* * *

[1-187] Q. Are you saying that part of the problem is the higher level directed down to the institution of Pennhurst?

A. Yes, I think that's true, and the manner in which decisions have been made so that some of the program people may have very little input in some of the key decisions, such as outtakes and that sort of thing.

THE COURT: All right. Thank you.

BY MR. THRASHER:

Q. Dr. Roos, have you completed your major recommendations?

A. Yes, I have. I am not sure I have been totally responsive to the Court in terms of problems of implementation.

I feel I should mention that part of the problem is the need to develop viable community alternatives. The staff at Pennhurst, I think, is keenly concerned about that.

* * *

THE COURT: If I may, I think it is better that I ask these questions now while you still have him on direct examination, if you want to develop something further and also counsel on some later cross examination.

BY THE COURT:

Q. You talk about implementation of these programs in the community.

Do you mean by that that, in effect, Pennhurst should be closed down and that we have separate facilities in small communities to take care of the
[1-188] problems that are now being taken care of at Pennhurst; or do you mean by the words "implementation in the communities" that certain of the now residents would better be taken care of in the community and still have institutions similar to Pennhurst, but along the lines that you are suggesting in your recommendations.

Which is it?

Have I made myself clear?

A. Yes, you have, and you have put your finger on a very key contemporary issue, because I think you will find that there is some division of professional opinion as to which of these alternatives is most desirable.

My own feeling is that as of now I have seen no compelling evidence that institutions can provide

better care than community programs and that, in general, it is most difficult for them to do so.

Now I recognize that to phase out a facility of Pennhurst's size takes time and takes very careful planning so that the residents truly leave there for more desirable settings; but I see no compelling reason at this time why Pennhurst should be retained indefinitely.

Q. Now along those lines, this might be comparable.

I just read or heard recently about the recommendation, I think coming from the Federal Government or some authoritative source, that we could [1-189] cut down, for instance, on the number of hospital beds throughout the country and, as I recall that recommendation, I think there was also included the suggestion that certain hospitals would be devoted solely to certain specializations.

A. Yes.

Q. Now in the interest of efficiency — and it seems to be that that is at least one school of thought — would you suggest, for instance, that there would be, in Pennsylvania, certain locations, not necessary in every community but some central locations, where some special type of treatment or facilities would be available for the retarded citizens?

A. Yes. It is conceivable that there might be small, highly-specialized types of facilities which would have at their focus dealing with small groups of individuals with very specialized needs that it might be difficult to meet in a community setting.

I see that as a possibility.

Q. Then perhaps what your suggestion is that you just don't do away completely with the concept of an institution like Pennhurst, we will say, if it were operated and proceeded along the lines of your recommendation, but in addition to community facilities

then we would still need certain, I will say, centralized treatment facilities and educational facilities.

A. There is certainly one model that has some real [1-190] possibilities. I think when we speak of such a model we are talking about facilities of fifty to a hundred, maybe at the outside, 130 beds; facilities which have a highly-trained and specialized staff, hopefully, which will not be warehouses for the individuals placed therein, but which will be transitory facilities where they will receive intensive treatment and training.

* * *

* * *

[1-193] Q. Let me be a little more precise about what I am after.

Did you form any definite views contrasting a large institution as you and I have discussed previously and as we have been discussing it today vis-a-vis the community-living arrangement?

Do you know when you made the judgment in your own mind that the institution was definitely not superior to or equal to the community-living arrangement as a medium for delivering services to mentally-retarded?

A. I think I reached that conclusion during the time I served as superintendent of the Austin State School, and that would be somewhere around 1965 or 1966, somewhere in that nature.

Q. What were the years that you served in that capacity?

A. Well, as I recall, it was from about '64 to '68.

* * *

[1-196] Q. You indicated that some of the myths that existed unfortunately with respect to mental retardation are still held today by professionals.

Can you elaborate on that?

A. I indicated that, unfortunately, some professionals still hold the myth.

[1-197] Yes, we are from time to time confronted with situations in which a pediatrician, for example, will tell new parents that they have a Down's Syndrome child, a condition easily diagnosed at birth. The parents are told, you know, that this is a hopeless case and you should institutionalize immediately.

Other professionals still hold the premise that mental retardation is really a kind of illness and the patient should be treated in the hospital.

Q. Are these specialists in the field of mental retardation?

A. They are professionals in their respective professions, i.e., Medicine or Psychiatry or what have you, as well as a lot of them in the field of mental retardation.

Q. Is there unanimity in the field of mental retardation with respect to the proposals that you have set forth today and the general ideas that you have set forth today with respect to institutions vis-a-vis community-living arrangements?

A. I would be most hesitant to attribute unanimity to any group of individuals, and that applies also to professionals in the field of mental retardation. There is quite a scope.

However, the Delphi study which I mentioned which did bring together a panel of recognized experts, did lead to unanimity on a number of the key points that I raised today, such as the tendency of large institutions to be phased out, the great growth of community-based programs, and the desirability of such community-based programs.

[1-198]

* * *

Testimony of J. D. Clements — direct

* * *

[2-12] BY MR. PEABODY:

Q. Dr. Clements, how are mentally-retarded persons different from normal persons?

A. I would like to turn that around a little bit and say that I think that mentally-retarded people are more like normal people than they are unlike normal people. For example, mentally-retarded people

[2-13] have the same ability to love, to hate, to feel joy, pain, sorrow, as you and I.

The most striking difference, I guess, that we would note when we observe retarded people is the development of some of their abilities to do things is at a slower rate than what we would normally expect.

Q. In what basic areas do normal persons develop?

A. If I can be general, we generally think about development as physical development, social development, intellectual development, and emotional development. Those are the broad categories.

Q. Does everyone develop in these general categories?

A. Yes, everyone, including retarded people, have developmental spheres in these catetories and certain capacities within these categories to develop.

Q. Is everyone born with the same capacity?

A. No.

Q. Is it then that individuals develop in these areas in different ways and at different rates?

A. Yes, they do.

Q. Is it determined at birth what an individual's capacity will be these areas?

A. No, it cannot be determined at birth.

* * *

BY MR. PEABODY:

Q. Now, Dr. Clements, you have stated it cannot be determined at birth what an individual's capaity will be.

Is there a certain age where these capacities
[2-16] can be determined in the areas that you have outlined?

A. Well, the determination sometimes, as we discussed earlier, is very difficult. I et me say that generally an individual is born with a certain capacity in various areas. It depends on what happens or does not happen to that individual whether or not that individual will develop up to that capacity or ceiling or whatever you wish to call it.

In the area of emotional development, ordinarily our capacity is fixed around the age of five or six years, so you either gain all that you are going to be able to get ultimately capacity-wise by that time.

With intellectual development we would say ordinarily by the time a person is 16 to 21 years, the intellectual capacity is fixed.

With physical development, generally, early adulthood in some areas, for example, the cardiac muscle, the heart muscle, we will say up to age 25. That's when the capacity would be determined.

As far as social development, which is probably the most important item here in the way an individual is able to live his life — in social development we continue to develop in those areas throughout life if given the proper opportunity.

Q. Those areas that you have outlined that have ceilings, as you put it, at certain age levels, I take it then that after those periods are reached one can
[2-17] only work within the capacity that one has reached at that age level.

A. That's correct.

I should be very clear on this. It is the capacity that becomes fixed. By saying the intellectual capacity has been reached does not mean that I can't continue to learn, but I can't learn at a higher or more efficient rate than what has already been developed.

* * *

[2-18] Q. Dr. Clements, have you had an opportunity to visit and evaluate the Pennhurst State School and Hospital?

[2-19] A. Yes, I have.

Q. When did you visit?

A. My visits were on March 24, 25, 26 and 27, 1975.

Q. Is that your only or most recent visit to Pennhurst?

A. Yes, it is.

Q. Could you describe generally for us what you did while you toured?

A. Yes.

On the first day we visited with the superintendent and other officials of the school, got information from them about the operation of the facility, the type of population that was there.

We asked the superintendent to give us examples of areas that he would suggest that we see, that he felt, for example, were the best that they had, an average situation, and the worst that they had.

The first day was spent really visiting all of the residential areas and certain of the program areas.

Q. Every residential unit?

A. Yes.

The second day, I think we finished with a couple of units that we had not visited the day before; and then did a more detailed visit to certain areas that were selected, including those areas given to us

by the superintendent. We continued that rather detailed examination of the units on the third day.

[2-20] The afternoon and evening of the third day were spent revisiting many of the areas, including photography of those areas.

The fourth day I spent examining records and than I had a summation conference with Dr. Youngberg and certain staff that he had selected.

Q. And during your evaluation you talked to the various professionals running various programs at particular departments, physicians, and the like?

A. Yes.

Q. Are these, in your view, people who are responsible for implementing the carrying out of practices and policies at Pennhurst?

A. Yes, they are.

Q. Now you mentioned that upon conclusion of your tour you had an interview with the superintendent and other professionals?

A. Yes.

Q. And what was the purpose of this interview?

A. The purpose of the interview was to discuss with them what I had interpreted that I had seen in case they felt that I had made any errors of understanding about what I had seen. It was an opportunity really to tell me additional things that I may not have found, and also to give them my impression of what I had seen at Pennhurst.

* * *

[2-28] Q. Dr. Clements, did you form an opinion as to whether the professional staff at Pennhurst during the time of your tour was adequate to provide minimally-adequate care and habilitative treatment to Pennhurst residents?

A. In my opinion, it was not.

Q. Are certain levels of direct-care staff also necessary to run any kind of minimally-adequate habilitative care and treatment program?

A. Yes. There are several standards, Your Honor, used for calculating direct-care staff.

The Wyatt order called for an overall ratio of one to one. That is, if you had 1265 residents you would need 1265 direct-care staff. They also break that down using mild, moderate, and severe, how you would use that.

The Joint Commission on Accreditation of Hospitals also recommends an overall ratio of one to one for most of the types of residents that you see at Pennhurst.

The regulations governing intermediate-care facilities for the mentally-retarded, which are the so-called nursing homes for mentally-retarded people, recommend as a minimum one to two.

[2-29]

Q. And are these —

BY THE COURT:

Q. Are nurses in the direct-care category?

A. No, sir, they are not.

BY MR. PEABODY:

Q. And are the standards that you have outlined also generally accepted by the professional persons in the field?

A. Yes, they are.

Q. Now is it particularly important for the direct-care staff to be appropriately qualified?

A. Yes, it is.

Q. Could you describe the kinds of qualifications needed to carry on the kinds of activities that they are there to carry out?

A. Well, I think an individual certainly needs to be, at a minimum, able to read, write well, and understand what is written.

He also has to provide for people additional training once they come to the facility to work and then again this is the type of thing that would certainly depend on the area in which they were going to work.

For instance, if they were working in an area where people were simply not ambulatory, you have to teach feeding techniques, you have to teach
[2-30] lifting techniques because these people can not get about and go to different places unless they are actually lifted out of bed to do so.

There are a multiple of things that have to be taught. On the other hand, you have to have a basic amount of education to benefit from that type of teaching.

Q. Did you form an opinion as the result of your tour on the qualifications of the direct-care staff at Pennhurst?

A. Well, I can only repeat what I told, that the average educational level of the direct-care worker at Pennhurst was the fourth-grade level and that, indeed, some could not read nor write.

Q. Did you ascertain the number of direct-care staff in census at Pennhurst on the date of your tour?

A. Yes, sir, I did.

Q. And did you form an opinion as to the adequacy of the direct-care staff at Pennhurst?

A. Well, if you take the total number of direct-care staff that were at Pennhurst, they fell between that one-to-one and one-to-two figure, so, numberwise, they would not quite meet what the Joint Commission recommends.

On the other hand, it was substantially above what the regulations for intermediate-care facilities for the mentally-retarded require.

However, they also require certain shift ratios. For example, the important thing is not how many

[2-31] people you have employed, but how many are at work, your actual number of units doing the job, so there are ratios spelled out for this.

For example, with the severely- and profoundly-retarded the Joint Commission recommended that there be on duty at least one employee to every four retarded people, that is, on the first two shifts; and at night they recommend that there be at least one employee for each eight individuals during the hours that they are ordinarily sleeping.

Q. Are there other factors at Pennhurst which draw the number of direct-care staff assigned to the particular ward away from the ward so that they are not on the ward to deal with the various residents?

A. Well, that's true not only for Pennhurst but any other facility. There are people that have to go on errands, there are people who have to arrange transportation.

As I mentioned earlier, you have got to provide time for these people not only to get original in-training service, but to keep updated on the training that they have; and that activity frequently would take them away from the ward area.

Q. Was that a particular problem at Pennhurst?

A. Well, yes. It's a problem at Pennhurst as it is at any other place when you have to pull short staff away from a living unit.

I did a survey of quite a number of the build-

[2-32] ings during the days that I was at Pennhurst, basically three days.

Q. Which units did you pick out for more intensive study?

A. I have C-10, K-1, C-9, D-1, C-7, C-8, and 52; and I did staffing ratios for March 22nd, 24th, and 26th, all shifts.

These were the people that were actually there in those theaters.

Q. Could you describe for us how you picked out these particular units to study more carefully?
A. Well, the units that I picked out included the three units that Dr. Youngberg had originally suggested that I look at and I picked out four additional units essentially at random.
Q. And for these units do you have figures as to the levels of retardation and could you compute the various ratios?
A. Yes, I did.
Q. Could you give us some examples, please?
A. C-10, for example, is a unit described for the severely-retarded and it is one of the units certified or was at that time as an intermediate-care facility for mentally-retarded.

On the 7-to-3:30 shift or the first shift on March 22, '75, the ratio was one to 30; on the 3-to-11, or second shift, the ratio was one to 61; on the third shift, the ratio was one to 20.

The ratios were similar the next day, the next two days.

For example, K-1, on March 26, 1975, the first
[2-33] shift, one to 24; the second shift, one to 16; the third shift, one to 24.

And C-8, which is said to be for profoundly retarded people with different behaviors, it is also certified for an ICF/MR unit, there are 36 people living on that unit. On March 22, on the first shift, there was a ratio of one to 12; on the second shift, one to 12; on the third shift, one to 18.

And on the 24th of March and the 26th of March the ratios were the same.

THE COURT: All right.

[2-36] BY MR. PEABODY:
Q. Now, Dr. Clements, in your opinion, does Pennhurst present an habilitative environment

where retarded individuals may grow and develop and reach their full potential?

A. No, it does not.

Q. Would you describe generally how it is deficient?

A. If I can speak generally, let's say that the living situation at Pennhurst is one of large day rooms, large sleeping areas, where large numbers of people congregate and live together.

In most cases there is no pretense of privacy, the noise level is extraordinarily high, the level of supervision of residents is low.

Programming at the time of my visit was almost non-existent.

You have a situation at Pennhurst in which individuals come into that facility and live in those conditions. If the individuals were talking, were able to speak, at the time of admission, with the noise level, the chaotic situations there, some of these individuals are likely to stop speaking because in that situation one can not use the language one has acquired.

If an individual is toilet-trained and the bathroom facilities are either not available or sufficient,
[2-37] one can no longer use those skills that one has learned in toilet training.

What I am saying is that the environment at Pennhurst is not conducive to acquiring new skills; indeed, it is more conducive to losing skills that one has already developed.

* * *

BY MR. PEABODY:

Q. Dr. Clements, I would ask you to look at Photo No. 1 on Page 1, if you will, and ask you if it is an accurate representation of what you saw on March 26, 1975, the day room in Residence C-9.

MR. GOLDBERG: Excuse me, Your Honor.

Is that Exhibit 48 again?

MR. PEABODY: Yes, Exhibit 48.

THE WITNESS: Yes. I was there at the time the photograph was made and certain things I think are noteworthy when one is looking at this photograph.

First of all, there are two individuals being bathed or assisted in bathing in the same tub. There is no provision for privacy despite the fact that there are three other residents in the room in various stages of bathing.

The bathing in the tub is being carried out by hose arrangement.

[2-38] It is a dangerous situation to have two residents in the tub together. You might look over at the other side of the photograph and you see a nude resident sitting in a wheelchair, also being bathed. The individual is what I would call a spastic person. Her leg is being pulled up into the air, putting her in a precarious position in that chair, from which she could easily slide out and injure herself.

There are a total of one, two, three, four, five residents and two employees in this bathing situation. I consider that a degrading, dangerous, and dehumanizing scene.

BY MR. PEABODY:

Q. Could you say what spasticity is, please?

A. Yes. Spasticity is a condition that's due to a central-nervous-system, that is, brain injury, in which the individual has difficulty extending, generally, the extremities fully. That is, it becomes very difficult. The muscles are, in essence, tight.

Q. Stiff?

A. Stiff.

Q. Is the bathing of two residents in one bathtub hazardous?

A. I would say so. If one resident slips he is very likely to take the other resident down with him. One resident can grab the other resident and injure him in that situation.

The employee, as you may note in that picture, is also leaning over at a rather precarious angle to be
[2-39] assisting the two people in the tub.

Q. Dr. Clements, I now refer you to Photograph No. 5 and ask you if it is an accurate representation of the toilet or bathroom area which you observed on Day 1.

A. Yes, it is. I was there at the time the photograph was made.

MR. WATKINS: Your Honor, K Building has since gone down.

I don't know if you want to spend time on these photographs. They are entirely irrelevent.

MR. PEABODY: Your Honor, I think we should briefly because there were residents living there at the time of the tour and they illustrate many of the relevant points which would be pertinent.

MR. WATKINS: I think we are only concered with respect to the United States and it makes no sense to me since that building no longer exists.

MR. GILHOOL: Your Honor, if I may, the superintendent of Pennhurst, on depositions, testified that 500 people at Pennhurst as of the date of the deposition, approximately six weeks ago, lived in buildings which he had recommended be torn down three years ago. They have not been torn down.

I think, therefore, pictures of K-1, which happily has been torn down, are nonetheless appropriate and admissible and relevant for looking at because
[2-40] there are evidently a good many other places similarly inhabited.

THE COURT: I will note your objection.

As to whether it is relevant the Court will take into consideration in making its finding your objection.

We will proceed.

THE WITNESS: The photograph that I am looking at shows a bathroom area. There are five toilets with no provisions for privacy, no toilet seats, in a large open room, in which the floor covering obviously is almost worn away, creating a problem of slipping, stumbling, and tripping.

Again it shows a complete lack of a sense of need for privacy of people.

BY MR. PEABODY:

Q. Dr. Clements, I now refer you to Photograph No. 6 and ask if you will —

MR. WATKINS: My same objection is noted for all the photographs that deal with Building K.

THE COURT: Yes, it will be noted for Building K, as long as somebody points out that this is Building K that they are talking about.

MR. WATKINS: Could I ask counsel for the United States to do that?

MR. PEABODY: I will mention Building K.

THE COURT: Yes.

THE WITNESS: This photograph is made in
[2-41] the same bathroom area previously described.

Again, you note the worn, hazardous floor covering; a break in the cover of the radiator with sharp metal prongs sticking out creating an immediate hazard.

Additionally, you may note in the photograph that the line leading to the radiator, the hot-water or steam, is not completely covered. The insulation has either fallen away or broken away, which is a hazard for people getting burned.

BY MR. PEABODY:

Q. Dr. Clements, I now refer you to Photo 7 and ask you if that's an accurate representation of Bathroom C in K-1.

A. Yes, it is.

Again, you note that there are three sinks. You do not see any soap or towels in this photograph.

I can also say that at the time of my visit there were not towels nor soap available for hand-washing at the time I was there.

Again, the same hazardous floor condition, you will notice.

Q. Does the absence of soap and towels have any consequences for treatment?

A. Yes, it does. Infection, the transmission of infections or communicable diseases is always a problem in congregate settings. It is more difficult to completely cleanse the hands without adequate soap and towels.

[2-42] Q. Does it also discourage residents from learning how to wash their hands?

A. When individuals are being taught by various techniques to do certain things, you do it step by step, in ways one would ordinarily expect them to be performed in a place where you ordinarily expect to do this.

Part of the steps of adequate washing are the use of soap and the adequate drying with towels following this procedure. If your hands are still wet following that procedure, again, then there is an immediate infection-transmission hazard.

So if individuals are taught in a situation in which there is no soap and no towels an individual does not learn the procedure properly to begin with. Obviously, if the individual did not learn the procedure properly, even if soap and towels were available in another setting, the individual is not likely to use them.

Q. Now, the deficiencies that you described in K Building on the date of your visit, were they occurring in other buidings?
A. Yes, they were.
Q. Not just K Building?
A. Not just K Building. This was a general deficiency throughout the facility, that is, lack of soap, lack of towels, lack of toilet seats.
Q. I now refer you to Photograph 39 on Page 20.
A. Yes.
[2-43] Q. And I ask you if that's an accurate representation of showering which occurred on Ward C-13.
A. Yes, it is. In essence, it shows one person who is an employee standing and observing two nude males in showers.

Again, there is no provision for privacy. The ICFMR regulations specifically state that there must be provisions for individual privacy in toilets, showers, and other bathroom facilities. It is a flagrant violation of the standards and the regulations.
Q. I now refer you to Photograph 42 on the next page and ask you if it is an accurate representation of a scene that you saw on Ward C-8.
A. Yes it is.

Again, there was congregate bathing in the bathroom. There were so many people in the bathroom that there was no adequate space, for example, for individuals to adequately dry themselves and change in the bathroom, so the procedure, as I recall it, was simply this — you went in and were showered and came out into this area for toweling and drying.

You may note that there are sheets or some other cloth material on the floor. The reason for that is that these buildings are generally built of hard-surface materials and when this flooring, for example tile or terrazzo, gets wet it is extremely slippery

and hazardous, so sheets were being put on the floors to try to cut down on that hazard of water on
[2-44] that hard-surfaced floor.

Q. I would next refer you to Photographs 43 and 44 on the next page and ask you if that's an accurate representation of showering on Ward C-8.

A. Yes, it is. It shows several nude females, again standing together, toweling themselves and being assisted in toweling, again with no provision for privacy made; the same type provision of sheeting material on the floor to try to cut down on the slipperiness or the hazard of slipping on the floor.

Q. You have used the term "congregate bathing."

A. Yes.

Q. Would you describe what you mean by that?

A. What I mean by this is that there are a number of individuals in the immediate area using the same facilities at the same time.

Again, the obvious objection that I would have, No. 1, is the lack of provision for privacy, plus in a chaotic situation of this type the possibilities of injury or accident are much greater.

Again, it is very difficult, for example, in this type of setting, where it is noisy, it is rushed, where there are a number of people there all together — it is very difficult to teach an individual to adequately bathe himself and one of the things that you are after or one of the first things to try to do is to try to teach individuals to help themselves.

If it is easier in this situation to do it for the individuals then let them do it themselves, therefore, there is a great tendency, Your Honor, to actually
[2-45] lose skills that you already have.

Q. Dr. Clements, during your tour did you have occassion to see residents being bathed but no soap being used?

A. Yes, I did.

Q. And could you tell us about that?

A. Well, yes. Again, it is extremely difficult to adequately clean a person without soap.

I saw situations, for example, in which a common bathcloth was used, in which there would be soap placed on that bathcloth and several residents soaped with this particular cloth.

Again, there is an infection hazard.

BY THE COURT:

Q. So you did see some soap there?

A. Yes. In other areas there was not soap.

BY MR. PEABODY:

Q. Were these congregate bathing practices you have described carried on in other buildings also during your tour?

A. Yes. That was the general situation rather than the exception.

Q. I now refer you back to Photograph 2 on Page 1 and ask you if that is an accurate representation of a
[2-46] bedroom scene on Building K-2.

A. I am sorry, which photograph?

Q. No. 2, Page 1.

A. Yes, it is.

Q. I am sorry, Photograph 2 is a non-ambulatory bedroom on Ward C-9.

A. What the photograph shows is a large number of what I would guess most of us would call crib-type beds, that is, they are beds with side rails to prevent individuals from rolling out of the bed.

There are a large number of these beds in a large open space. In fact, the beds are so close together it is difficult to get in between.

It would certainly be difficult to move individuals out in this situation. The problem again, as you will note in the photograph, is that with all of these beds and people lying in beds, there is an individual

in bed nude. I assume they were in the process of changing a diaper or changing clothes, again, with no consideration or provision for privacy.

Q. Is this resident also spastic?

A. I beg pardon?

Q. The resident that you described, is that resident also spastic?

A. The patient appears to be from the photograph. He has quite a contorted position.

* * *

[2-47] BY THE COURT:

Q. I noted that in commenting on several of the photographs you pointed out that the individual in the photograph was spastic.

A. Yes, sir.

Q. What is the relationship between that condition and retardation generally?

A. It is an associated relationship, Your Honor, in people who have cerebral palsy and who are spastic. About one third of those individuals are retarded.

It is a condition that frequently is also found — it is a symptom that is also frequently found with the symptoms of mental retardation. They frequently occur together.

Q. Is there any explanation that the medical profession has as to why that should occur together on so many occasions?

A. Well, there are certain conditions in which you would find both the spasticity and the mental retardation.

* * *

[2-50] BY MR. PEABODY:

Q. Doctor, are spastic conditions and other like-related conditions due to poor or inappropriate physical therapy?

A. Yes. The spastic condition *per se* would not be due to poor, inadequate physical-therapy techniques. The situation that you would get into is that the situation would become more severe because of lack of proper intervention techniques.

For example, an individual is usually, say, around six or eight months of age before this spasticity is recognized. At the time it is recognized the muscles are not as stiff. Generally, one can still extend the arms fully, the legs fully, go through the full range of motion that you and I could go through.

Unless some rather sophisticated techniques are used, including physical-therapy techniques, and are used with great intensity the individual will develop what we call contractions, that is, the arm may be flexed back in this position, bent, pulled backward; and when an individual develops a contraction the arm can no longer even forcefully be straightened by another individual.

[2-51] So what you attempt to do with the physical therapy is to keep the arm moving so that these contractions do not develop because once the contracture develops the only way that you would really straighten this arm is by surgery.

Q. I take it then that early intervention is important for remedial actions for this condition?

A. It is, vitally important.

Q. Now referring you to Photo No. 19 on Page 10, I now refer you and ask you if it is an accurate representation of a bedroom area on Ward Q-2.

A. Yes, it is. Again, the photograph shows large numbers of individuals sleeping in beds quite close together.

I am having a little difficulty seeing these photographs from the glare, but the photograph, I believe, represents an individual lying in bed, restrained on the lower left-hand side of the photograph.

Q. By the ankles?

A. Restrained by the ankles, and I am not sure, there may well also be an arm restraint but I can't see that photograph very well.

* * *

[2-54] BY MR. PEABODY:

Q. Dr. Clements, I now refer you to Photographs Nos. 29 and 30 on Page 15 and ask you if they are accurate representations of bedroom areas on Ward 47.

A. Yes, they are. Again, what the photographs depict is a large open area with hard-surfaced floors, hard-surfaced walls, high ceilings, in which there is some attempt made at visual privacy for the residents. There are low dividers separating the area into areas of one to two beds in each of these divided areas.

Again, this divides only for minimal visual privacy, particularly while lying in bed, but again provides no auditory privacy.

The situation that one runs into, particularly at night, in an area like this is if one individual is having difficulty sleeping or is crying, coughing, what have you, it is disturbing to the rest of the individuals in this area.

Q. Is there a problem in these areas also in terms of lack of appropriate stimulation?

A. Yes. Again, as I said, the walls again are hard-surfaced, the floors are hard-surfaced.

It is rather barren. There's minimal furnishings, no decorations.

In my opinion, it is very unstimulating environment except from a negative sense. The high noise
[2-55] level would be stimulating in that condition.

Q. Now are the problems that you described in the bedroom areas that you have described typical and representative of other such areas in the institution generally?

A. Yes. Most of the sleeping areas in the institution are not unlike this.

Q. Dr. Clements, I now refer you back to Photograph No. 12 and ask you if it is an accurate representation of the non-ambulatory female day room on Ward C-9 on the date of your visit.

* * *

A. Yes, it is, and the photograph shows a number of individuals sitting around unattended, inactive, no program is going on.

The thing that I think is most obvious in this photograph is if you take a look at the wheelchairs and the other equipment that's being used in this area, this equipment is not adapted, sizewize or otherwise, to the particular needs of the individuals using the equipment. The problem with this is this:

Individuals who are spastic tend to assume the most comfortable position, as you or I would, and what happens inevitably is that this position over long periods of time tends to become fixed.

Therefore, if you take an individual, for example, at one point who really was able to sit upright,
[2-56] because of their condition and the lack of adaptive conditions is allowed to slide down or sidewise into her wheelchair, eventually this individual can no longer assume any other position.

The only way that I know to prevent that individual of this type is to fit that chair to that individual's needs and utilize the chair and the proper fit-

tings in order to support the individual in an upright position.

Now the upright position is vitally important because, as you will note from the photographs, the striking thing here is that both sides are looking down, and if an individual spends their waking hours looking down their world is very small. Their world is the floor or their lower extremities.

An individual does not learn while in this position, so it is an actual hazard to the individual in the sense that it narrows the scope of their world and narrows the amount of intellectual stimulation that an individual receives and physically it is a great danger if the individual becomes fixed in that position and the only way the individual will ever again get out of that position is by rather drastic surgical procedures; and there is no guarantee that those surgical procedures would be effective.

Q. Can you describe briefly how appropriate physical-therapy procedures adapt the chairs so that they become individualized?

A. Again, the individual would have to be actually measured and the chair would have to be padded or
[2-57] stuffed or built to fit the contour of the individual's body in order for there to be any support for that person.

The individuals here can not sit and maintain an upright position as you and I can. They need the assistance of special equipment to allow them to do so and the startling thing about this photograph is that this is standard equipment that you buy in certain standard sizes.

That equipment is supposed to be further adapted to that individual's needs before it is used by that individual; and in this case, as you see, it is not.

Q. I now refer you to Photograph No. 21 on Page 11 and ask you if it is an accurate representation of the day room on Ward 48.

A. Yes, it is; and again the thing that you see so striking in this photograph is a large room, obviously hard-surfaced floors, walls, ceilings.

The light is shining, glaring off of those surfaces.

A large number of people sitting around the perimeter of this room doing nothing. It is quite obvious that this is not the middle of the night. It is obviously in the daytime with the light shining in those windows.

It is again a barren environment. There is an obvious lack of planning. The individuals are simply sitting there whiling away their lives.

Q. I now refer you to Photograph No. 26 on Page 13
[2-58] and ask you if it is an accurate representation of the day room you viewed on Ward 47.

A. Yes, it is, and the scene is essentially the one which I described in the photograph before — again, the large day room and a number of individuals sitting around, in which organized activity obviously is not going on except between one employee and one resident.

Q. I now refer you to Photograph 32 on Page 16 and ask you if it is an accurate representation of a corridor on Ward 48.

A. Yes, it is. Again, it shows a wide expanse of corridor, a long corridor, again with hard-surfaced materials both on the floor and the wall. It is tunnel-like in appearance.

Again, as I recall, when I was there the noise level was quite high. It is just another representation of a very drab, barren environment, which is not uncommon at Pennhurst.

Q. Are the drab and non-stimulating environments you described typical of most like areas at Pennhurst?

A. Yes, they are.

Q. Now what consequences does that environment that you described and the lack of staff that you described and some of the professional practices you have described have on the residents at Pennhurst? What is the impact?

A. The impact on the residents at Pennhurst is essentially a situation in which one is more likely to regress than to progress.

[2-59] As I stated earlier, individuals who come into this type of environment frequently lose the ability to speak. Individuals who come into crowded, chaotic environments, who were walking, tend to lose the ability to walk.

Individuals who come into this environment and they don't have proper programs, proper equipment, such as the adapted wheelchairs I was talking about earlier — these individuals who are able to sit upright tend to lose the ability to sit upright.

In other words, individuals don't gain skills. The more likely situation is that they will lose skills.

Q. And your professional opinion is that the environment at Pennhurst fosters this regression and loss of skills?

A. It does.

Q. In your opinion, does the environment also foster the occurrence of physical injuries?

A. Yes, of course, it does.

When you have individuals, for example, who have some difficulty anyway in getting about because they have physical defects of many kinds, seizure disorders, whathaveyou, when you have hard-surfaced floors, for example, they become extremely slick when wet, and it was not uncommon at

Pennhurst, for example, to see wet floors from showering, floors wet with urine and other materials.

[2-60] There were maintenance problems at Pennhurst. I think if you look at the radiator cover that was broken, things of that type, that increased the likelihood of accident and injury.

When you have large numbers of people congregated together, particularly milling about in a chaotic fashion, one individual tends to injure another individual.

There are numerous scenes at Pennhurst that I saw of individuals that were suffering from repeated old injuries, injuries that had occurred repeatedly.

I remember one scene, for example, late in the evening on one day that I was at Pennhurst. We were going about and there was one direct-care person sitting on the ward and there were a fairly large number of adolescent males in this unit that were quite active, and when we entered the room one young man was severely beating another young man.

The employee was sitting there watching. When the superintendent who was with me at the time questioned the employee as to why are you allowing a situation to occur? Why don't you intercede?

The employee's remark was that's not in my job description.

Q. Doctor, I now refer you to photograph numbered 25 on Page 13 and ask you if this is an accurate representation of the resident you saw in Room K-25.

[2-61] A. Yes, it is.

I think I spoke just a few minutes ago about the fact that there were so many residents that had remarkable scars representing repeated old injuries.

Q. Is this an example of that?

A. This is an example. It is a young man sitting on the floor, as you will notice, his scalp — his scalp is just criss-crossed with scar tissue.

Q. Did you see numerous other residents with other such evidence of prior injuries —

A. Yes.

Q. — in your visit?

A. Yes, I did.

You know, it is a little more dangerous than it looks on the surface of this because with repeated injuries to the skull, the head, what one can eventually end up with is a situation which we sometimes see in prizefighters, when they say they are punch-drunk.

You get repeated contusions to the brain and you decrease your intellectual capacity when that happens.

Q. Dr. Clements, did you note any other deficiencies which placed residents in imminent danger of possible threat of physical harm or death?

A. Well, yes. I mentioned, you know, that when you have large groups of people together you immediately increase the hazard, regardless of your traffic.

[2-62]

When you have inadequate traffic, of course, you just compound the error.

Q. Did you observe any improper feeding techniques during your tour?

A. Yes. There were a number of errors at Pennhurst, in which the individuals there are essentially confined to bed unless they are taken out.

I observed on several occasions feeding going on in those areas; and in certain cases, individuals who were being fed were lying flat.

If you have ever tried to drink water when you are lying flat in bed you can understand the difficulties of doing this.

In addition to that, most of these individuals are again cerebral-palsied or spastic as we were talking about earlier; and because of that you have even more difficulty than you and I would in swallowing food or liquid.

So you create an immediately-hazardous situation, hazardous to life by feeding an individual, No. 1, without knowing and utilizing the proper feeding techniques; and, secondly, by feeding them flat. It was not unusual at all to see individuals lying flat while being fed with the expected result of coughing and choking during the process.

Q. Can you describe generally what the proper
[2-64] feeding techniques are for such persons?

A. Well, for a person who is spastic, or any other person, they need to be as upright as possible while feeding, while they are either feeding themselves or while someone is assisting or completely feeding them.

You need to know if the individual has difficulty swallowing and if there are certain techniques that you can use to assist that individual.

For example, you can stimulate the individual's lower lip to help him in the swallowing process. There are many techniques that can be used.

It is hazardous at best when you are feeding another person, particularly a person who is spastic and has difficulty.

Special feeding utensils are required at times. I recall very well seeing an individual — while I am not sure at Pennhurst, when I recall on my tour at Pennhurst, being fed applesauce.

This individual was absolutely flat in bed and this individual finally coughed and spewed out the entire amount of applesauce that they had been fed.

The applesauce had gone to the lungs rather than the stomach. This creates an immediately-haz-

ardous situation to life, not only from choking and immediate aspiration, but the fact that it increases the chance of acute and chronic pneumonia and ap-
[2-65] parently damage to the lungs.

Q. Are there also hazards for persons who are in inappropriately-fitted wheelchairs, so that, therefore, they don't have good position when feeding is done?
A. Yes. The same hazard would exist as I have just described.
Q. And did you see a number of the kinds of inappropriately-fitted wheelchairs that you described a few minutes ago, throughout the institution?
A. Yes. This was generally the situation. It was not the exception.

There was very little adaptive equipment used at Pennhurst on the time of my visit. Of course, most units did not have enough wheelchairs for the cerebral-palsied or spastic patients.

In many instances Therapy used many times what is generally referred to as cripple-carts. They are wooden carts with what appear to be bicycle wheels and these are used to roll people about in the flat position.
Q. I refer you to Photograph No. 11 on Page 6 and ask you if that is an accurate representation of the kind of cart that you have just described, this wooden cart being on Ward C.
A. Yes, it is. It shows an individual lying in that cart, which I have referred to as a cripple-cart, covered, essentially, by what appears to be a sheet or a blanket.

Just the top of the individual's head is visible.
[2-66] The individual is obviously in a very awkward position lying there.
Q. And is this the kind of person who could have had the feeding problems that you have described?
A. It is; not only that, but individuals with severe

spasticity and cerebral palsy tend to have difficulty even handling their own secretion, that is, swallowing their own saliva; and they tend to choke on that as well.

It would be very difficult for a person in the position in which you see this individual lying. It would increase the hazard of aspirating their own secretions.

It would be really difficult for even the individuals to really cough up their secretions in that position.

Q. With proper feeding and proper training can the hazard you have described be reduced?

A. The hazards can not be eliminated. They can certainly be substantially remedied.

Q. Now you have mentioned that one of the results of improper feeding can be aspiration, aspiration pneumonia, I believe you mentioned?

A. Yes.

Q. Can you describe what these terms refer to?

A. Well, for example, if one is attempting to eat and swallow and rather than the food going down into his stomach it goes down into the lung, food acts as
[2-67] a foreign body with tissue. It sets up an inflammatory reaction within the lungs, which then also tends to become infected and you get a pneumonia, just as you would from getting it with any other bacterial agent.

Individuals of this type tend to repeatedly aspirate at least some amount of materials and get a chronic pneumonia and chronic lung damage and that's the problem with which you are dealing.

Q. Is asphyxiation also possible.

A. Oh yes. Individuals do choke and because of their inability to get air in and out die. This is always a hazard with a person who has difficulty handling secretions and food. You increase that hazard by

utilizing improper feeding techniques and improper position.

* * *

Q. Dr. Clements, I now hand you government exhibit marked No. 13, death records, Pennhurst State School and Hospital, January, 1974, to January of 1977 and ask you if you have reviewed that.
A. Yes, I have.
Q. And what are these records?
A. These are records, some post-mortems and some not, of the diagnosis of the individual who has expired — the cause of death.
[2-68] Q. Do they include autopsy reports?
A. Some do, yes.
Q. And do others include clinical notes, progress notes, where the events leading to the death are described?
A. They do.
Q. And could you tell us why these records are customarily kept in institutions, including Pennhurst?
A. Well, records are kept in this fashion to give one an appraisal of what is happening in the situation.

For instance, at a general hospital you would also keep records of this type and it is for an assessment of the effectiveness of your program.

For example, if we found in an area that there were deaths, a substantial number of deaths due to injury, this would give me some cause, for example, as to what might be going on in that particular area and what might be done about it to correct the situation.

The records are an assistance to let you know what is going on and to assist you in improving and providing the best quality care for them.
Q. So that the records reporting occurrences from

certain deaths, certain deaths might be prevented in the future?

A. One would certainly hope that it would be of assistance in that regard, yes.

MR. PEABODY: The United States would
[2-69] move into evidence Government Exhibit No. 13.

THE COURT: It will be received in evidence.

(Plaintiffs' Exhibit P-13 received in evidence.)

BY MR. PEABODY:

Q. What do these records indicate, Doctor, by way of death by aspiration, aspiration pneumonia, and asphyxias?

A. There were a substantial number in these records. As I recall it, at least 10 deaths allegedly due to that cause.

Q. Do you have any opinion —

BY THE COURT:

Q. 10 deaths within the period —

A. Of less than two years.

Q. Less that three years?

A. Two years, I believe.

MR. PEABODY: 1974 through the first month of 1977.

THE COURT: All of 1974, all of '75, all of '76, and the first month of 1977?

MR. PEABODY: Three years; that's correct.

* * *

[2-70] BY MR. PEABODY:

Q. Doctor, do you have any opinion or impression as to why there are such deaths by aspiration and aspiration pneumonia and asphyxiation?

A. No. As I said, the situation at Pennhurst certainly makes it likely that this type of thing is going to occur.

I would have to go back and examine each case to know if what was, in fact, the cause or this were the situation that happened.

I would not form any impression from these records of the deaths related to the deaths at Pennhurst. I simply wouldn't be able to.

Q. But you have concluded upon your review that there were deaths by aspiration, aspiration pneumonia, and asphyxiation?

A. That is correct.

Q. And within your experience, sometimes not necessarily in these exact cases, poor feeding practices lead to such deaths?

A. Poor feeding practices can lead to such situations.

Q. And within your experience, can proper feeding techniques perhaps reduce the incidence of such deaths by aspiration, aspiration pneumonia, and asphyxiation?

[2-71] A. Yes, without question they can.

Q. During your tour, Dr. Clements, did you observe any other feeding techniques or feeding practices which were, in your opinion, inappropriate?

A. Yes. On several occasions which we observed in feeding there was an unusual amount of time, for example, between the time that the food was placed on the table and the resident was able to utilize the food.

At one situation that I can only describe as very gross, one evening, as I recall, the time between the time that the food was placed on the table and the residents began to eat their food varied roughly from 14 minutes to 45 minutes. The food was cold at the time.

Another problem is that there were large numbers of people eating in that room and you really couldn't provide any assistance to the residents who

were eating, some simply gulping the food and some, in some cases, using spoons and some hand-feeding.

In certain patients, one resident would steal food from another resident so that he got more and the other person got little or none.

A great deal of the food went onto the floor.

Again, one of the problems in this situation is the very rapid way that an individual eats. It is hazardous because he is simply cramming it down very quickly.

[2-72] One reason that this occurs is that with people sitting so close together, if they don't eat quickly their food is stolen.

It certainly, in no fashion, in my opinion, allows the residents to eat in a normal fashion or to enjoy meals that are served. It is a situation more of survival than pleasure.

Q. Dr. Clements, I now refer you to Photograph No. 34 on Page 17 and ask you if that is an accurate representation of the dining area in the basement of Building 2 and an example of the practice that you have just described.

A. Yes, it is.

Q. I would next refer you to Photographs 36 and 37 at Pages 18 and 19 and ask you if that is an accurate representation of feeding which you observed on Unit 3 during your tour and again examples of what you described.

A. Yes. It shows an individual eating with the hands very rapidly, the first photograph does; and the second photograph shows her not only eating from her tray but from the tray of the child sitting next to her.

There is no way in this situation, No. 1, to control the adequacy of the diets of the people here. There was no portion control to begin with. When it

was put out it was esssentially the same amounts that each tray began with, whether you were little,
[2-73] large, fat, thin, or what, with the additional hazard of someone else always eating your food.

It was just virtually impossible to have any real diet control for the people involved.

Q. Then I take it from what you have said that careful monitoring of such diet is important?

A. Yes, it is. It is particularly important, you know, for people in a situation where they are growing, as it is with all children, all adults. It is even more important for people who have physical handicaps, for example, not to be overweight because you are adding an additional burden to the physical handicaps that they already have.

Q. Is it also important in terms of simple malnutrition?

A. Oh, of course, yes.

Q. Dr. Clements, from your evaluation of Pennhurst were you able to ascertain whether the environment was such that there was a lack of appropriate programming areas, areas in which activities could be conducted?

A. Yes and no. In many situations there were too many people and too few spaces.

In other situations there were spaces that were unused. For example, on several occasions we went down to the area that was supposed to be utilized for physical therapy and at no time that I went there did I find any activity going on.

In other areas, particularly on the living areas, where, in fact, most of the individuals were at the
[2-74] time of our visits, the spaces were too few. One of the problems that you get into with that situation is this — I don't care if you add a hundred employees in one of these large day rooms with 15 or 20 or 30 people, you still couldn't accomplish anything other

than control of the situation, which many times would be an improvement.

What I am saying is you couldn't break groups down into small groups that could relate to an employee as a person, as another individual, because it was noisy and there were no dividers and there was no equipment to do this.

The problem, the ultimate problem, that you get into in this situation is that many retarded people already have a handicap relating to each other as people. They simply are not able to develop the interpersonal relationships which you and I would.

In a home, where there is a mother and a father and several children, it is confusing even there because several people are giving them signals day by day. Some of them are contrary. The mother may be saying one thing, the father another.

But in a situation like you have at Pennhurst, where you may have 15, 20, 30 individuals living in one area and that many employees that you are dealing with on a 24-hour basis, on three shifts, it becomes virtually impossible to develop any kind of interpersonal relationship and the confusion is im-
[2-75] measurable because you may have, in the course of a day, a hundred people telling you to do different things differently and it is just not a situation that is conducive to learning.

Q. Does your answer suggest conditions which would be more conducive to learning?

A. Well, I would say that with a situation with 25 people living, or if you improved it to 20 people living, it would be much better if you could improve it to five or four or three.

Q. In other words, the smaller the group the more efficacious the treatment can be?

A. It makes it — it makes possible for better treatment.

Q. Dr. Clements, I now refer you to Photograph No. 13 on Page 7 and ask you if that's an accurate representation of the basement motor training area in the D Building.

A. Yes, it is. I referred to this area a few minutes ago when I was talking about going to this area several times and never finding it in use.

Again, it is a large area which has been an attempt at subdividing the space with sheets or other material. Again, it is an inadequate area for the purpose that it is supposed to serve.

Q. Was it empty during the times of the day when you would have expected to find residents there?

A. Yes, it was. In fact, we got a schedule of the times that the area was supposed to be in use because I was particularly interested in seeing what was going on there and, as I recall, we went there three different times and it was not in use.

[2-76]

On one occasion there were several employees there but no residents.

Q. On the basis of your evaluation did you determine that generally throughout Pennhurst there was a lack of programming activity going on while you were there?

A. Yes, I did. It is obvious when you go to the residential units where people live and they are there and they are not in programs, they are not in organized activity. I think the situation was obvious.

Q. Dr. Clements, I now refer you to Photograph No. 14 on Page 7 and ask you if it is an accurate representation of the conditions on D-3 that you showed us before.

A. Yes, it is. It shows a child sitting on the floor who appears to be digging material off the floor. Again I think this is just symptomatic of much of what was not happening at Pennhurst.

The child is unsupervised, apparently has noth-

ing else to do, is spending its time in the best way that it can, that is, simply picking up material off the floor.

Q. Is this actually a dangerous activity?

A. Yes. it could be ingested.

Q. Dr. Clements, I now refer you to Photograph No. 23 on Page 12 and ask you if it is an accurate repre-

[2-77] sentation of the residents you viewed on Ward 52 during your tour.

A. Yes, it is. This is a young man who is simply lying on the floor of a day room in the middle of the day, apparently with nothing else to do.

The head is blocked out in the photograph. I don't know whether the individual is asleep or not, I don't remember.

Again, it is an example of lack of organized programs and activities.

Q. Is Photograph No. 24 below a similar accurate representation of the inactivity on Ward 52?

A. Yes, it is. It shows another individual. Again, he is lying on the floor unattended, untouched by this program.

Q. Did you observe these kinds of inactivity, if you will, throughout the institution during your tour?

A. Yes. They were not limited to that area.

Q. Can you draw a conclusion on the basis of these observations?

A. Well, one would have to immediately assume that there were not organized programs going on at the time of the visit.

Q. Dr. Clements, did you also have an opportunity to review individual patients' records at Pennhurst to determine whether these records supported your conclusion that there were inadequate individualized programs going on?

A. Yes. The part of the records, No. 1, is an evalua-

[2-78] tion of what this individual needs. The records des-

ignate the priorities, what do you attempt to do first with a certain individual.

Now what that has done, it has to be explained on the record in language that ordinary people can understand. It is also a 24-hour record or should be of activities of this person leading toward accomplishment of the goals, those priorities that you have already determined.

Without this the only assumption I can make is, No. 1, the evaluation did not occur; and, No. 2, there is not a real or realistic plan of treatment for that individual.

Now in addition to what I have already said there should be observation, documented by the staff, of how well this is working or is this occurring; so there is no point, for example, if you are teaching an individual to tie his shoes, what he learns to tie his shoes, there is no point in teaching him to do that for another 25 years.

So the record really is there to assist everyone who has any relationship with this record to assist that resident in increasing his skill. That is the purpose of the record.

I did examine a number of records at random. Those records were chosen for me by the staff of Pennhurst. I did not select which records that I was going to examine.

Q. In your opinion, are individualized treatment plans for each separate individual necessary in order for the habilitation process to proceed?

[2-79]

A. Yes.

Q. Could you give us from the records you have reviewed a couple of examples of how the records either don't contain such a plan or are deficient in terms of currently-accepted professional standards for that kind of records?

A. Well, the records were inadequate and incom-

plete. For example, they list — one record listed as a short-term goal, and a short-term goal is independence and prevent injury.

The method stated to do that, to accomplish those short-term goals, is dressing, bathing, and safe environment.

There is nothing there that I could utilize really if I went in and had to care for that resident that would tell me how to accomplish a short-term goal of independence and prevent injury for that resident.

The long-term goal is to prevent stasis edema, increased socialization.

The method is good nursing care, foster grandparents, UAS, sewing and cooking classes, eventual transfer to appropriate ward.

Again, there is nothing there that would help me to know how to assist the resident in accomplishing those long-term goals. In other words, the records are of no benefit.

Another one that I looked at, the short-term goal was decrease hyperactivity. The method was
[2-80] daily recreation with foster grandparents.

Long-term goal — maintain present health status. The method of doing that is medicines given properly, keep bowels open, good skin care.

An observation about this individual for whom this plan was developed is has been resting well at night. Still quite active in dining area. Slides chair all over floor area to get close to other residents in order to rip strings off their gowns. Just loves to sit and play with strings.

I don't see anything in that observation that really gives you any followup in what you had said that you wanted to help that resident accomplish.

Those are not atypical of the records that I examined.

Q. In fact, they are representative?
A. Yes, they are.

* * *

[2-82] Q. Dr. Clements, in your opinion, are there certain control measures which institutional personnel resort to in lieu of efficacious programming activities?
A. When you have a situation again dealing with large numbers of people, a short staff, you have injuries, you have accidents, you have all sorts of things happening.

One of the things that you have to try to do is to get the situation under control so that you don't — so that the incidence of all of these things that I have mentioned doesn't increase.

Without adequate staff and without an adequate treatment program there are certain other things that people tend to do in lieu of that staff and treatment program. One is physical restraint. Another is chemical restraint. Another is psychological restraint.

But very often these things are used not as a part of a treatment program *per se*, and they can be
[2-83] a legitimate part of a treatment program. They are used instead of treatment.

For example, if a resident is hyperactive, to decrease the problem with that they give them a lot of pills to the point, generally, though, that the individual is groggy; and an individual who is sleepy can't learn, can not utilize what skills he has already developed.

Or you can use a physical restraint in which an individual is tied down and can not get up to move about.

Again, an individual who is tied down can not go to places where one would learn, can not use the skills that he has learned.

If he is in a bed he is restrained and even though he is toilet-trained the bed becomes a toilet. He can't get to the toilet.

So these are the things that happen. Sometimes they are necessary as a part of the treatment program, but these are the things that happen instead of a treatment program if you don't have an adequate environment and you don't have an adequate staff.

You see, the tragedy of all this is that much of these behaviors that we are trying to cut down on are really situational disorders. The behavior is a reaction to the situation that you find yourself in.

If you look at any of the standard textbooks, for
[2-84] example, in Pediatrics, Nelson's textbook which is published here in Philadelphia, you talk about headbanging, you talk about biting, all of these things that we so commonly see in institutions.

The textbook says that these are generally situational disorders, and what is the treatment? Correction of the situation that you are in — not pills, not physical restraints.

So we are creating a condition in this situation that treatment is inadequate.

Q. Do you have an opinion that those measures are being resorted to at Pennhurst as control measures?

A. Yes. In my opinion, they are.

I know of nothing, no other thing that they could do at the moment, I would say, except that it is a matter of trying to bring the situation more under control because they didn't have adequate facilities to do the job that they should have been doing.

As a matter of fact, there were a number of people at Pennhurst, as I well know, at the time of my visit that shouldn't have been there to begin with; and many of these people were reacting to a bad, inhuman, almost intolerable living setting and many

of these behaviors that I have just talked about were developed because of the setting.

Q. When you say that there were people there who didn't belong there, could you describe the kinds of

[2-85] persons, the characteristics or whatever that they possessed?

A. It would be much easier, I suppose, to try to describe the characteristics of a person that belongs there rather than one who didn't belong there.

Q. All right.

A. As a matter of fact, I didn't see, during my visit to Pennhurst, a single individual that should not have been in a less restrictive setting.

Q. Away from Pennhurst?

A. Yes.

Q. Now you mentioned when you were describing the use of these control measures that under some conditions they could be a legitimate part of an entire treatment program?

A. Yes.

Q. Could you please describe how these measures are used appropriately, as you mentioned?

A. There are a few cases, a few conditions in which an individual is self-abusive, that is, an individual may repeatedly hit his eye to the point that the eye will become non-functional, the individual will become blind.

For example, in the (Lexnihan) syndrome, that is a part of a condition of self-abuse. You have to use restraints in that condition because you weigh the consequences.

The consequences of being in restraint are less drastic than an individual continuing to injure him-

[2-86] self, blinding himself, but these are very rare situations.

You have other situations in which an individual needs temporary assistance with chemical con-

trol. The entire idea is to provide that temporary system with chemical controls to enable the person to take advantage of the other programs that are offered and by doing so hopefully no longer need the chemical control.

But when you provide the chemical control without the other program the only purpose for the drug is simply control and you are going to have to continue the drug because you have nothing else to offer and these drugs are not without dangers.

Some of the results are irreversible. Some of the drugs —

Q. I take it from what you have described that these devices, if used at all, should be used under careful control, for short durations of time, in conjunction with an active activity-type-of-treatment program?

A. That is correct. For example, if you take a physical restraint, if you tie someone's wrist, you have got to check it repeatedly to make sure it is not too tight, because if you cut off the blood you can destroy the extremity.

It takes an extraordinary level of staffing and expertise to properly use restraints. It takes an unusually knowledgeable staff to properly use chemi-
[2-87] cal restraints. It takes more staff to properly use them than to not use them, so really, if they are used as an adequate treatment method, it is going to take more staff rather than less.

On the other hand, when you see it most used, unfortunately, is where you see the least staff, the least program.

Q. Can the use of physical restraints result in injury?

A. Yes, of course, it can.

Q. I refer you to Photograph No. 18 on Page 9 and ask you if that is an accurate representation of a resident in restraint on Q-1.

A. Yes, it is. These are vinyl or leather hand restraints, in which both hands are thrust into the restraint, in which the resident obviously cannot remove his hands from the restraint.

Q. Is this a potentially-damaging situation?

A. Yes, it is.

Q. How come?

A. Well, obviously, the resident can not learn, or if he learns, can not do certain things for himself.

How would this resident go to the toilet unassisted? How would this resident attend a class?

How would this resident fend off the attack of another resident?

Q. Dr. Clements, do you have an opinion regarding the use of certain tranquilizing drugs commonly used in institutions in lieu of efficacious programming, as you already testified?

[2-88]

A. Ask that question again, please.

Q. Do you have an opinion as to how certain tranquilizing drugs are used in institutions in lieu of efficacious programming?

A. Well, yes. I think they are essentially overused in many institutions, including Pennhurst.

The Federal Drug Administration, up until about a year ago, never approved psychoactive drugs, tranquilizers, for behavior control of retarded people; so, as far as the FDA was concerned, there was no approval at all.

This is not to say that retarded people don't become emotionally ill or mentally ill as well. Unfortunately, we don't use drugs adequately for that class of people.

For example, if you take the retarded person in a situation like this, who is depressed rather than hyperactive, that person is likely to get no attention at all. He does not get "the benefit" of a drug.

On the other hand, if that person is running

around, hitting other people, spitting, or other things, regardless of whether that person is mentally ill and whether that drug is treatment specific for that condition, that person is likely to be tranquilized by a drug.

My survey of institutions in the United States shows the average percentage of people in institu-
[2-89] tions for the mentally-retarded runs about 55 percent of all people in those institutions. Generally, they are not kept on one tranquilizer but on several.

I don't know percentage-wise how many people or what percent of the people in institutions should be on drugs. It is certainly much closer to 25 percent than 55 percent.

It would have to be determined on an individual basis, depending on the individual resident's needs.

Q. Did you get an impression that drugs were overused at Pennhurst?

A. Again, I would not be willing to say that any specific individual at Pennhurst is incorrectly on a drug because I didn't look at it from that standpoint.

I do have figures here in my report somewhere to give the discrepancies that I found when I randomly found that certain units — and this is on tranquilizers — for example, in Ward C-7, 65 percent were on tranquilizers, and on Ward C-8, 54 percent; on Ward C-9, 25 percent; and on Ward C-10, 50 percent.

You know, it is a very interesting phenomenon when you look at the institutional population and the use of drugs. You will find a very nice figure of ambulatory people on tranquilizers.

If you look at the non-ambulatory group, that is, that are confined to bed, there is an extraordinary low figure generally in institutions; and my only conclusion is I don't know why people in bed should
[2-90] need treatement more or less than people who are not in bed.

My only conclusion is if you are in bed you can't get up and raise hell and the only reason that most people are on tranquilizing drugs in institutions is because you are raising hell.

* * *

[2-93] Q. Dr. Clements, what are your major impressions and recommendations for Pennhurst based on your review of the facilities?
A. My impression as listed in my report is really that the major problem that we are dealing with at Pennhurst is that it represents the wrong concept, at the wrong time, and in the wrong place.

Pennhurst has, in my opinion, outlived its usefulness to the retarded citizens that it attempts to serve.

The environment at Pennhurst, both physically and psychologically, is totally counterproductive to even adequate custodial care. It is entirely unfit for the purpose of habilitation.

[2-94] There is overcrowding, inappropriate environment, and lack of habilitation programs, which result in physical, psychological, and emotional deprivation and in most cases immediate hazard to the safety and wellbeing of the residents, as well as physical, social, and emotional deterioration of the residents.

There is a drastic lack of facilities. The physical structures are inadequate.

There is an inadequate complement of direct-care personnel on duty. Middle management is spread beyond its ability to offer effective managerial support. Adequate quality and quantity of professional staff is not available.

Programs of habilitation are not available in adequate quantity to prevent continuing physical, emotional, and social regression.

Physical and chemical restraints may be substituted for lack of programs and adequate environment.

My feeling after visiting Pennhurst is that a majority of the residents, provided proper community resources were available, could be placed back in the community and reasonable progress for the residents could be expected to occur.

BY THE COURT:

Q. Would you explain what you mean by "placed back in the community"?

A. Yes, sir.

[2-95] We often get frightened at the prospect of people being suddenly and abruptly removed from institutions and dumped back into the communities. A second frightening aspect of this is the specter of spiraling costs to provide these programs.

By placing back in the community, I think that the process should be, No. 1, each resident at Pennhurst would be evaluated on an individual basis to know what that individual's strengths and weaknesses are. A determination will need to be made of what programs would be beneficial to this reident, as well as the type of environment that would be most conducive to that resident's progress.

Once you know that a determination could then be made of what resources you already have at Pennhurst could be reshifted back to the community.

For example, it should not cost the State of Pennsylvania enormous sums to do this if they will utilize the resources that they already have at Pennhurst and redirect those resources into more corporate programs.

The most important single thing that will be accomplished for the residents, No. 1, is a more decent situation in which to live and a situation in

which we will make it possible for that resident to receive and benefit from adequate treatment.

It is my opinion that if you supply everything that you should want for Pennhurst today you [2-96] would end up with a situation that would bankrupt the State of Pennsylvania; you would end up with a situation in which you basically had control, you could control what was going on there.

I don't think that you would end up with a situation that would be decent to live in nor a place that would be conducive to treatment of the residents living there.

When you put people together in a situation like this, large groups together, you just increase the handicaps. People model their behavior from the behavior to which they are subjected.

Your Honor, there is simply no way that I know that you can prepare a resident of Pennhurst to go back into the community by anything you could do at Pennhurst. To prepare the situation in that community you redistribute the resources that they now have at Pennhurst to the community and then you will have a system of community programs and you won't need a large institution at Pennhurst.

* * *

[2-99] Q. Let me ask you then, Doctor, without going through the specific pictures — there were several there, several of the pictures in the exhibit that was shown to you, getting back to what you said about several of them represented children or people, retarded people, with spastic conditions.

It certainly appeared from those photos that at least in several instances people appeared to be bedridden, practically.

A. Yes.

[2-100] Q. How would we take care of them under your plan in the community?

A. First of all, if you compare the difficulties of caring for a person like this compared with certain other people, for example, I don't think it is as difficult to care for a person, if you use the term "bedridden," as it is a person running about and hard to keep up with. I feel it is less of a problem.

You do realistically, though have to have certain provisions in which you can get physical therapy, et cetera, and you can be taught in the home to do certain of these physical-therapy features.

It may be necessary during certain hours to send in a home-nursing service to dress the person, get them out of bed, bathe them, put them in a wheelchair — that sort of thing.

Q. Then I do understand that you are saying that the community concept that you are advocating is one that would provide a residence in presently-existing homes?

A. I think that would be the most appropriate situation, Your Honor.

Q. In other words, you are not recommending or suggesting building facilities that may in some way resemble the present institution that you are now the head of, or resemble Pennhurst, but on a smaller scale in each community?

A. I would strongly advise against it.

Q. Then how do you justify, for instance, the exist-

[2-101] ence of the institution that you are now heading, and I don't mean that as a trap question? I just wondered how that would fit in.

A. I don't justify it, Your Honor. In fact, what we are doing at the present time is, in the development of community programs in Georgia, we know that there are not going to be substantial State dollars available to do this, so what I will do, for example, I

will contract with a local community and I say to them if you can make placements and maintain four or five people in your community, then I will give you these two or three jobs to do it.

It would have been necessary to have them in the institution to care for these people. You can use the job, you can use the money that goes with it, and this will maintain in the community more people than the same dollars would maintain within the institution.

* * *

A. It is in Atlanta.
Q. Right in Atlanta?
[2-108] A. Yes.

My last recommendation is to discontinue all admissions, new admissions, to Pennhurst.
Q. Dr. Clements, have you had any experience in the implementation of the kind of recommendations that you have made for Pennhurst?
A. Yes, I have.
Q. And could you describe briefly for the Court what those experiences have been?
A. I guess the most intensive experience has been with the order in New York State relating to Willowbrook. At the present time I am chairman of the Willowbrook Review Panel, which is an arm of the Federal Court in the Eastern District of New York, which was appointed by Judge Judd to oversee the implementation of the court's order.

The implementation of it is the most difficult part of the litigation. The problem has been turning around a State system. There is no way that we have been able to make Willowbrook a good place to live.

The annual budget at Willowbrook at the present time is $70,000,000 per year. Even with

that $70,000,000 and literally thousands of new employees it is still not a good place.

[2-109] The most dramatic improvement at Willowbrook has been due to one thing, and one thing alone; and that is a decrease in the population.

MR. GOLDBERG: Your Honor, I can't hear the witness.

THE WITNESS: It is a decrease in the population of Willowbrook.

It is my feeling at this point, after being involved in this for several years, that with very little more money Willowbrook had in the beginning, very few additional employees, but had the population decreased as it has done at the same time the results would have been the same as they are today.

So the critical issue is the decrease in the density of the population in which people live and I would say that that, in and of itself, is the most critical factor at Pennhurst. It is far more important than generally the lack of resources that I described.

BY THE COURT:

Q. Now at Willowbrook has there been or was there, I should say, a determination that in the future more people should be treated in the community —

A. Yes, sir.

Q. — or housed or reside in the community rather than at Willowbrook?

[2-110] A. Yes, sir. When the Willowbrook case first came about there were 6500 people — 6,500 people — at Willowbrook. It was the largest institution for the retarded in the world. It is located on Staten Island.

The order states that the population of Willowbrook shall be decreased down to not more than 250 remaining people there at the end of the jurisdiction

of the court. All other people shall be in community programs, living in the community.

Q. Let me ask you this:

How long have you been associated with that court decree?

A. I have been on the Review Panel since July of '75.

Q. Did the implementation of that decree, if you know, require any legislation as far as the State or the Federal Government or the local government?

A. No, sir. The important of what we have learned there is this — you have to have some mechanism to follow up on the order, not that you are implying that people are untrustworthy. The problem is the people who are trying to carry out the order very rarely need a quarterback for them.

You see, you are existing in a situation of conflict of interests, with certain orders in a system initially.

What I think that we have been most helpful in doing, that is, the Review Panel, is to provide expertise to the people in the Department of Mental Hygiene in the State of New York and to also assist them in doing what needs to be done. We have been able to take a lot of the flak off their backs, in other words.

[2-111]

We have had a fortunate situation in that the State of New York also wanted to implement that order and was sincerely committed to do so and the Review Panel and the State have been able to work together toward trying to get it done, but it has meant a turnaround of the direction of mental hygiene.

Q. I am going to ask you the same question I asked your predecessor on the stand — I don't know whether you were here or not — but during your visit to Pennhurst and your opportunity to confer

with the superintendent and the staff generally, did you discuss this type of community programs and what you think is the proper determination to return these people for residency in the community?

Did you discuss that with them?

A. Yes, sir, I did.

Q. Generally speaking, did you find much opposition to your recommendations?

A. As I recall, they were certainly strongly supportive of the development of the community program as I was.

* * *

[2-124] Q. One other thing in your testimony, Doctor — at one point you said that, in your opinion, 100 percent of the residents of Pennhurst could be placed in a community facility if an appropriate one existed; and at another point you said, I believe towards the end, that some persons may have to stay at Pennhurst, the multiply-handicapped who need continuing medical care.

Just for my own clarification, which is it? Could they all be put in the community or would some have to remain at Pennhurst?

A. May I quote myself accurately?

I said I didn't see anyone at Pennhurst that I didn't think could be in a community program. That was the first quote.

The second quote was I said the last individuals, in an effort at depopulation, the last individuals that I would see remaining at Pennhurst would be those that required constant and continuous medical and nursing assistance in order to survive.

Q. Would they have to stay at Pennhurst?

A. No, they would not.

* * *

Testimony of Allen Taub

* * *

[2-139] BY MR. FERLEGER:

Q. Mr. Taub, would you state your age and occupation, please?

A. I am 56 years of age and I am a partner in the meat business.

Q. Have you, in the past years, had any involvement on any official or formal basis with Pennhurst State School and Hospital?

A. At the present time I am president of the Parents and Family Association of Pennhurst. I am also a member of the Parents Staff of Pennhurst; also a member of the Woodhaven Center at the Woodhaven State School, and I am residential chairman of PARC, Philadelphia; also, I am a Board member of the Philadelphia Association for Retarded Children.

I have also been on investigation committees out at Pennhurst, one with Stan Meyers, rather, Mr. Miller, Stan Miller, and also represent CO-MHAR out at Pennhurst and also had the honor of picking the two superintendents for Pennhurst.

* * *

BY MR. FERLEGER:

Q. Mr. Taub, do you have a retarded child?

A. Yes, I do, my daughter, Linda, who is 26 years of age.

* * *

Q. You, on behalf of your daughter, have participated as a plaintiff in this lawsuit?
A. Yes, I have.

* * *

[2-145] Q. What made you decide to turn to Pennhurst for the care of your child?
A. Well, Linda went to a few different schools and we just believed in home environment and, you know, we thought that Linda — we just couldn't let go, that's what all parents do, self-denial. We just don't want to accept the fact that one day you have to make that decision.

Linda was at the age of 15 years of age and we went through quite disturbing nights and sleepless nights and this is something that people don't understand unless you have a retarded child, the emotions, the family strain, the draining, you live abnormal. It is not a normal way of living.

[2-146] Consequently, if we went somewhere we would always have Linda on our minds and we were called from places to come home. It was chaos.
Q. Who was taking care of your child at home?
A. Well, my son. I had a son, Gregory. He was helping out.

We tried to get some babysitters and they would go as far as they can and then they would call and we'd have to come back.

But it got to the point where it is either a nervous breakdown for the entire family or for my wife or myself. Besides Linda being home for 15 years, we got to realize that we, as people, as her parents, have other children, plus the fact that we have other obligations and we had to live our own lives too.

And it came to the point where we had to make that decision and we finally decided that there was no other recourse but an institution.

Q. At that time was there a waiting list for admission to Pennhurst?
A. At that time Pennhurst, as everybody said, there was a waiting list of over 2,000 people waiting to get into Pennhurst.
Q. And did you put Linda on that waiting list?
A. We put Linda on the waiting list and we waited and finally she was admitted.
Q. How long did it take?
[2-147] A. It took maybe around six to eight months.
Q. At that point did you know what sort of program or situation Linda would go into?
A. Well, at that point I would say the family was at the point of desperation and at that point any recourse, any avenue to turn to, would be welcome; so it was just going into a blind situation.

The most important thing was to give what we call now respite care to that family. The family needed help and that was the only place to turn to get it.
Q. Okay.

And did you have any difficulty making that decision?
A. We didn't sleep for nights and we didn't sleep for days. It was one of the most nervous times of my life and it was very upsetting.
Q. Why was that?
A. Because we believed in family, parents, home environment; and we just didn't want to leave go, I guess, but we had to.
Q. When was Linda admitted to Pennhurst?
A. Linda was admitted in 1966.
Q. Do you remember the month?
A. It was October; either it was October or November.
Q. Did you and your wife take her there the first day?

A. Well, I could say that was one of the saddest
[2-148] days of our lives, when we took Linda to Pennhurst. It was a rainy day and it just was in my mind.

We rode. Linda was in the middle, between both of us, and we took her out of the house at 8 o'clock in the morning and it took us about an hour — an hour and a half to get there and we cried. We cried until we got there and that's the way it was.

Q. Now did you go with Linda to the ward that she was admitted to or not?

A. Well, when we came there, there was a little waiting room and the usual hard bed and we were in the lobby waiting for someone to come down and take her.

Q. In the administration building?

A. No. This was in another building. I guess it might have been in T. I really don't know if it was in the hospital unit, but we were in a little lobby, like.

Q. Were you permitted to go to the ward with her?

A. No. We left Linda there.

A person came down. In fact, I would say the social worker most likely, I believe, Mrs. Marshall. She came out and greeted us and they took Linda and that was — that was it.

[2-150] Q. Were you permitted to visit there?

A. C-1 Unit was the worst unit that I have ever encountered. C-1 Unit was a place where you had to come up the steps and you had to bang on the door for maybe half an hour before somebody would come out and let you in.

Q. Do you mean that literally, a half an hour?

[2-151] A. Literally. By the time of the banging on the door, and again people don't seem to understand that people, parents, have feelings when they go into a place like that on the beginning, to get acclimated.

You have to visit and you have to keep banging and banging and no one answering, that was very annoying.

Finally, that caused the bell system to be originated in Pennhurst, so when you came later on you would ring the bell, and this is what parents had to interject into the institution to at least give us the courtesy when we came, don't let us wait, we will ring the bell so people there will know that we are here and they will come out to the door.

Q. Do you recall your first visit to that ward? Will you describe the ward to us?

A. That ward you normally didn't get into. That was a closed ward, but one day I got into that ward and it was what you would call, you know, being into a situation like this for the first time, just like you would see White zombies, people walking around like that in an enclosure, all in straitjackets, and walking with their arms all tied up.

And I was wondering where my daughter was and there was Linda on the floor, in a straitjacket, just sitting there on the floor.

Well, my first impulse, the first time I saw that, it was like traction, the worst I saw —

[2-152] Q. Now did there come a time in 1968 in the fall when Linda was in a wheelchair at Pennhurst? Will you describe that?

A. Well, Linda, finally, after very hard maneuvering and I was very lucky, we were able to get here out of C-1, which I call the snakepit. That was one of the worst wards I have ever seen.

We managed to get here out after several months of trying and we got her into C-8, and C-8 was a lot better.

One day we came up to visit Linda and you walked right up, and I couldn't find my daughter. Me and my wife were looking for her. We just couldn't find Linda.

And we passed by this little girl and then we realized that that must be Linda, and she was in a wheelchair and her arms were strapped around and

they were in a position where she couldn't get out of the wheelchair.

Q. Now was Linda a person who was able to walk?

A. Linda was able to walk. Linda was blind but walking was not a problem.

Q. What was she tied to the wheelchair with?

A. Well, it seemed like, you know, the whatyoucallit, the straitjacket tied around and she was just with her head down, and one of the things, the coloring on her face, you know, I believe in exercise, I believe people should be walked around.

But her face, her sallow complexion, being in a wheelchair, being tied up, that left a harmful image.

Q. Did you ask any staff why she was tied up in a wheelchair?

[2-153] A. Well, we asked and it seemed that that was the best thing they could have done with her at that particular time, that that was the best thing for her, that particular setup, because she was constantly being turned around.

They felt that putting her in this position they would know exactly where she was.

Q. That would keep her from walking around?

A. Well, that's the way it seemed at that present time.

Q. Now during the period of time that she was on C-8, which was until April, 1970, from 1968, could you describe any programs that Linda was involved in?

A. There was about maybe one program as far as I could actually realize. That was like a feeding program, trying to develop her eating potential and trying to get her eating habits developed.

Q. Was there any other program that you know of?

A. As far as I would say, very little programming.

Q. How did Linda spend her time?

A. Most of the time, as these two gentlemen here, witnesses, described, it was sitting on hard benches.

One of the things we protested more than anything else was the garment that stayed on and half the time with no undergarment, and exposed; no shoes. The feet would be one of the worst you could see. Everybody walked around barefooted.

Q. Everybody on the ward?

[2-154] A. Most of the people in the ward had no shoes.

Q. What proportion were clothed or naked?

A. Well, you had a percentage of people always taking off their clothes and you had people sitting on the hard chairs naked.

I mentioned quite a few times some of these chairs, if you ever visit, some of them weigh 50 or 75 pounds of hard wood; and when the kids would get hyperactive in some of these cottages, they got power, they got strength, they throw the chairs over.

And talking about kids getting hurt or why, you could just be walking by at that particular time and the chair would come over and it sure could break an arm or a leg.

I mentioned many times that they ought to replace those chairs, those hard rock chairs, with something a lot softer there. That doesn't require much money.

* * *

[2-159] Q. According to the records, Linda went to Ward I-1 in May of 1970 and stayed there until September, 1973, when she went to Ward H-1.

Could you describe the conditions on Ward H-1 in 1973?

A. Ward H-1, I think the unit system at this time began to become a little effective and the population

here was a lot reduced. There might have been maybe 30 in the cottage, I am not sure, and we had — there was an old building that had to be constantly renovated and fixed. The bathroom facilities for some reason always seemed to be the worst in Pennhurst and, as the gentleman said here before,
[2-160] there were cracks on the floor and water deposits. It was very easy to slip and just fall, which happened over and over again, and the same constant no-program.

Q. What was the condition of the toilets?

A. Well, the toilets — you never had toilet seats.

Q. No toilet seats?

A. Yes. You sat right on the bowl and you sat on the cold bowl and some kids would sit there for hours, just sitting there with their feet up.

And we are talking about maybe one or two attendants with around 30 people.

Q. And what would the attendants be doing while the residents were sitting on the toilet bowl?

A. Unfortunately, there is so much activity to be performed with two people that it was totally impossible to really know what was happening in the front and the back.

The physical structure was completely no good for two attendants to observe.

Q. Would residents be left unsupervised?

A. Residents were left alone. If you don't bother me, I don't bother you; and this is the sort of setup you had.

The resident would go into a bed in the back and lay there for an hour or two, I mean, that's the way the setup was, because that was due to the lack of help. They just couldn't get around and get these people out.

[2-161] Another thing a lot of the kids would do is there was a constant banging, you know, where they would just hit their heads on the wall.

Q. And what would the residents do in response?
A. When you say "residents," we are talking about—
Q. I mean aides. What would the aides do in response?
A. The aides — everything was taken — a lot of things were taken for granted, that this is the way it should be.
Q. When a resident was engaging in head-banging what would the aide do?
A. Well, they'd be busy. They would be preoccupied with other things and we used to — we played the role of father. A lot of people never had parents that would come and we would say to them stop, and I asked many, many times for what we would call a child-care attendant aide on the ward.

This type of aide would be just walking around and her job was to see that the abuses would stop.
Q. The aides weren't engaged —
A. The aides didn't have the time; they just couldn't handle that situation.
Q. Were children ever lying in bed with any material that shouldn't be there?
A. Well, that you had. You had children that unfortunately, like the gentleman said there, when they had to go when they were in bed that was the thing that happened.

* * *

[2-169] BY MR. FERLEGER:
Q. Did he provide any care to Linda Taub?
A. No. We brought his report back to Pennhurst.
Q. And did you see that report?
A. Yes, and then —

BY MR. FERLEGER

* * *

[2-170] Would you characterize the progress or the lack of it that you feel your daughter made during her years at Pennhurst from 1966 to 1975?

A. I think there is only one way and it would seem that as far as we are concerned as parents, there was regression.

Q. Excuse me. Regression?

A. Yes, that Linda went down.

The only thing that Linda got at Pennhurst was strictly custodial care.

* * *

[3-13] **Testimony of R.L. Sprague**

Q. How is your experience in psychopharmacology uniquely involved with the field of mental-retardation?

A. I think it is uniquely involved. There have not been a great many people in this country, unfortunately, interested in this area.

I have been chairman of the FDA Subcommittee which deals with this particular problem for the nation.

I have up until recently the only research grant issued by the National Institute of Child Health and Human Development to study the effects of
[3-14] psychotropic drugs, which are the drugs given in psychopharmacology, the effect of these drugs on mentally-retarded patients in institutions.

Q. Are you also necessarily familiar with psychopharmacology as it relates to mental illness?

A. Yes, I am.

Q. Could you please distinguish between mental illness and mental-retardation?

A. Mental illness is a condition in which the person needs treatment, psychiatric treatment, because of psychotic disturbances or neurotic disturbances, usually causing bizarre or unusual behavior.

The mentally-retarded is an entirely different problem in which there is slow development, usually from birth, so that the person's primary problem is slow learning and does not necessarily involve the bizarre, unusual behavior that typifies the mentally-ill.

That is not to say that the mentally-retarded cannot also be mentally ill at the same time. In fact

there are a few mentally-retarded individuals that also are mentally ill, but that is more rare.

* * *

[3-23] Q. Doctor, did you visit Pennhurst State Hospital to evaluate the prescription, distribution and administration of psychotropic drugs?

A. Yes. I visited Pennhurst on March 3rd and 4th, 1976.

Q. What was the general method of conducting your evaluation?

A. Prior to arriving I asked for a random sample of the residents to be generated and Dr. Youngberg's secretary — a list was given to me and I attempted to visit the wards or units of each of those residents, read the medical records for approximately a year, talked to the direct-care nurses and attendants that might be in attendance on that ward; and in some cases speak briefly to the residents.

THE COURT: Let me interrupt again.

[3-24] BY THE COURT:

Q. What was that date again?

A. Your Honor, March 3 and 4, 1976.

THE COURT: Thank you.

BY MS. CHRISTENSEN:

Q. Did you also have occasion to speak with any staff at Pennhurst State Hospital?

A. Yes, I did. When I first arrived I asked for a meeting with Dr. Hedson, chief of medical services, Mrs. Helen Francis, chief of nursing services, Mr. Norman Benner, who is the head of pharmacy, and Mr. Peter LeMaire, Associate Superintendent, also attended that.

We discussed problems and policy regarding prescription and distribution and monitoring of

psychotropic drugs at Pennhurst for approximately an hour and a half.

Q. Did Dr. Hedson indicate any particular problems to you at that time?

A. The problems that were discussed involved the distribution and monitoring of the medication, how it was distributed, and particularly most of the time was spent with the training of the aides that actually administered, that is, give to the residents their medication.

Q. Did Miss Francis give you any information during that interview?

A. Yes, she did. She indicated there are problems
[3-25] with the current system they have in the sense that they are using non-professionals in the sense that they are not nurses or licensed practical nurses to pour, which is the Pennhurst term meaning that the medication from the bottle on the unit, the tablets are taken from there and placed in individual cups for the individual resident by an aide, and that aide is a person without any particular specialized training for their employment in nursing service, to give them in-service training to handle this rather difficult assignment.

Q. Did Mr. Benner give you any information regarding the drug system at Pennhurst?

A. Yes. He was extremely helpful and gave a lot of information about his work since he has been at Pennhurst.

He described the distribution system, the storage system, and he particularly had information on total usage at Pennhurst during the past five years; and he gave me that information.

Q. Prior to leaving Pennhurst did you have any opportunity to discuss your findings and conclusions with these same Pennhurst staff members?

A. Most of the same staff members, part of the afternoon prior to leaving I had an opportunity to talk with Dr. Hedson and — Mr. — I am sorry, Mr. LeMaire, Mr. Foster, and I believe that's all.

Q. And at this time did you discuss your recommendations and your findings and conclusions with them?

A. Yes. We outlined in general detail my findings and recommendations, particularly when we spent
[3-26] most of the time discussing the inadequacies in the monitoring system, that is, the system which they use to check to see whether the drugs are actually doing what they expect them to do with the residents.

Q. Did they disagree, express any disagreement, with your conclusions and recommendations regarding monitoring of the ill effects?

A. No. As I recall, there was general agreement on the inadequacy of the records.

Q. Dr. Sprague, were you provided with any materials at the time of your evaluation of Pennhurst State Hospital?

A. Yes. I requested that the nursing service give me twenty-six different guides, memoranda, and manuals.

MS. CHRISTENSEN: Your Honor, may I approach the witness?

BY MS. CHRISTENSEN:

Q. Dr. Sprague, I hand you Government's Exhibits No. 32 and No. 33.

Have you had an opportunity to examine these exhibits?

A. Yes, I have.

Q. And can you describe to me what those exhibits consist of?

A. Exhibit 33 is the material used by the nursing service in the training of medicational aides in

dispensing psychotropic medication and other medication.

* * *

[3-34] Q. Have you reached any general conclusions as to the adequacy of the medication — course-of-training materials?

A. Yes, I have. I believe they are inadequate in terms of the amount of material that is available and used at other institutions and generally available; the length of time of the training, twenty hours as indicated; and the standards for checking subse-

[3-35] quently the child-care aides in the usage of the medication.

Q. Dr. Sprague, how did you conduct your survey of individual residents' medication?

A. I tried to visit the ward where the resident lived and then talked briefly to the nurse or the aide that was there, and then reviewed the medical records, the doctor's orders for the last year, particularly noting the medications that had been given or no medication; the reason it was given and the monitoring or the checking for the effects of the medication during that year.

Q. How many residents on the random sample did you actually review?

A. Thirty-nine.

Q. Do you consider that this is a statistically-representative approach?

A. Yes, I do.

THE COURT: May I interrupt to ask a question?

BY THE COURT:

Q. Were you able to obtain any figures as to the number of residents at the time you were there in March of 1977 to whom, I should say, these drugs

— and when I say "these drugs," of course, I am referring to the psychotropic drugs — had been administered?

A. Yes, your Honor. I calculated that information and of those residents, 51 percent were receiving psychotropic medication.

Q. 51 percent at the time you were there were receiving it?

A. That's correct.

[3-36] Q. Did you have any information that would indicate what the percentage would be concerning the number of residents who had, during the period that they were there, received this type of medication?

A. No, I didn't examine the records. I can only assume, basing on the residents' charts that I evaluated, what might be true; but I did not — I don't have that over a period of years, how many might have received medication.

Q. The figures that you received then, I think you said 51?

A. 51 percent, your Honor.

Q. 51 percent of the residents that were there at the time, March 3 and 4, 1977, were receiving these drugs?

A. That's correct.

THE COURT: All right. O.K.

BY MS. CHRISTENSEN:

Q. Dr. Sprague, going further, what percentage of the residents that you reviewed received anticonvulsants?

A. 35 or almost 36 percent.

Q. Did you determine what percentage were receiving both psychotropic and anticonvulsant drugs?

A. Yes, I did, and that was 30 percent receiving both the psychotropic and the anticonvulsant.

Q. What percentage of the residents you reviewed were receiving two or more psychotropic drugs?

A. There were 40 percent of the residents receiving

[3-37] psychotropic drugs that were receiving two or more of the drugs at the same time.

Q. What is this practice commonly referred to?

A. It is commonly referred to as polypharmacy.

Q. Will you tell me what the hazards of polypharmacy are?

A. There a whole range of hazards giving two or more drugs at one time.

Sometimes the drugs don't simply add up, but they combine and create problems that would not occur if each drug is given individually. That's called potentiation interaction.

Also, there are a number of contraindications, if you look in the medical literature, that this particular drug should not be given with another particular drug, so there is an additional hazard of giving several drugs at one time because of that.

Finally, if one is attempting to assess, to monitor the effects of the medication on the residents, and again that is the reason given, it is next to impossible to figure out which drug is causing what if there are several being given at one time.

Q. Doctor, do you consider that the percentages of drug usage which you outlined previously — 51.3 percent on psychotropic medication and so forth — did you consider this percentage significant?

A. Very significant — high.

BY THE COURT:

Q. What was the last word? I didn't get that.

[3-38] A. Pardon me — high, quite frequent use.

Q. On what do you base that statement?

A. I base that opinion on survey work that I have done in the country and some overseas, and my visiting other public facilities for the mentally-re-

tarded, and most particularly recently the Georgia Mental Retardation Center for the most disturbed ward, where the most severe problems occurred, and 25 percent of the patients were receiving medication.

If you would look at the total facility the frequency would be much lower than 25 percent.

BY MR. CHRISTENSEN:

Q. Doctor, is that mental facility the same facility run by Dr. James Clements?

A. Yes, it is.

Q. And are any of the wards on that facility comparable to the wards that you observed at Pennhurst?

A. Comparable in the sense of the degree of severity of the problems and the recurrent behavior.

Q. Doctor, did you observe any trend in drug sales at Pennhurst Hospital?

A. Yes, I did. There were two trends.

The total usage of Thorazine and Mellaril had declined over the past five years, but unfortunately the usage of the three other or four other medications had rather dramatically increased during the past three to four years.

[3-39] Q. The figures on which you are basing your determination as to these trends were provided to you by Mr. Benner; is that correct?

A. Mr. Benner, that's correct. Mr. Benner kept this information and volunteered the information to me.

I went to see him; he pulled his records and gave me this information. I wrote it down and then calculated the total usage.

Q. And from the figures which Mr. Benner had given to you from Pennhurst State Hospital — from the figures that he gave to you what were the percentage increases in these drugs — Haldol, Prolixin, and the last one?

A. Haden in the last few years increased 900 percent; lithium in the last four years increased 800 percent or more; Prolixin in the last four years has increased 400 percent; Haldol in the last five years has increased 240 percent.

Q. Are the drugs which have increased in usage approved by the FDA for prescription for mentally-retarded persons?

A. They are approved for use with psychiatric problems. They are not specifically approved for use with the mentally-retarded.

Thus we are in a situation if the mentally-retarded are psychotic, have severe problems with depression, for example, that would be the case with lithium. They are appropriate to be used, but they are not specifically approved for the mentally-retarded.

Q. What is your professional opinion of the drug
[3-40] utilization trend that you have indicated?

A. Well, particularly with lithium, which is a medication very useful for the depressed, manic-depressed patient, I haven't seen a manically-depressed retarded individual.

I am not saying they don't exist. If they do exist, excessive numbers exist at Pennhurst, at least as indicated by the 800 per cent increase in the use of lithium.

Q. Doctor, can you give us some specific examples of problematic practices at Pennhurst State Hospital which you observed?

A. Yes, I can. I referred to some of the cases that I saw when I visited there. I catagorized them and I have given them a number.

Case 4 involves an individual who was receiving three psychotropic medications and one anticonvulsant medication — Haldol, two milligrams three times a day; Valium, ten milligrams on

a PRN or as needed order; Mellaril, 200 milligrams three times a day, which is 600 milligrams a day; and Dilantin, one gram at night.

That's interesting because the new FDA recommendation on total dosage per day for Mellaril and Thorazine is 400 milligrams, and this was 200 milligrams over that, 600 milligrams a day, in addition to the other medications that the individual was receiving.

Q. Do you have any other examples?

A. Yes. Case 7 was receiving ten milligrams of Valium as needed, PRN: Stellazine, ten milligrams
[3-41] twice a day; Mellaril, 300 milligrams twice a day, which again is 600 milligrams, above the 400-milligrams suggested limit.

Very interestingly, with this particular case there is just a hint of behavioral monitoring in the doctor's orders and what is said is good and friendly.

It puzzles me, if that is the classification of how the resident is behaving, why so much psychotropic medication.

Patient 20 received a number of psychotropic medications. I have this date January 6, 1977, he received Cogantin, two milligrams twice a day. Cogantin is a medication given to counteract some of the problems that occur because of the use of the psychotropic drugs. He received Prolixin, one cc; Benadryl, 50 milligrams at night, thereafter 30 milligrams as needed; Haldol, ten milligrams three times a day, and Benadryl 50 milligrams a day.

What is particularly interesting in this case is how the patient is evaluated for the effects of this rather extensive medication and back over the years, in every case, the reason for giving this was upset behavior.

That's certainly not a very clinical or technical description, except in one case, on February 10, 1977 it is indicated very upset.

This indicates almost a total lack of any essentially adequate monitoring.

[3-42] Case 23 received several psychotropic medications. The interesting situation is that on December 5, 1976, when shackles, as needed, were ordered for twelve hours, along with chloral hydrate, 50 milligrams immediately.

Q. Do you consider that a significant order for shackles and chloral hydrate at the same time, Doctor?

A. In my experience I am very surprised that shackles would be ordered on a PRN basis at the determination of the staff.

These are some of the more outstanding cases. Let me refer to one other, 29, where seclusion for twelve hours was ordered on a PRN basis at least twice.

Q. And what was the reason indicated for ordering seclusion at that time, Doctor?

A. Intoxication.

Q. In your experience is this a reason for ordering seclusion?

A. No, it isn't.

Q. Doctor, did you observe PRN or as-needed orders for behavior modification in the orders which you reviewed?

A. Yes. There was quite a number of that. In fact, I looked at that number and it is roughly 30 per cent where the psychotropic medication was PRN.

Q. Do you understand what the policy of Pennhurst is with regard to PRN administration of behavior-modification drugs?

A. I think I understand that.

Q. And on what do you base your understanding?

A. The memorandum written by Dr. Youngberg in 1973 outlining the policy.

[3-43] Q. And what did that document say?
A. Well, it is permitted on the basis of a prescription of a physician, if the physician has prescribed the PRN medication.
Q. Is that for a standing PRN order or just a situational order or occasional PRN order?
A. I am not able to precisely ascertain from the medical records. It would appear to be standing because there are on some occasions stat orders. "Stat" means immediately which means that there has been a call usually and a particular problem arising, so the physician will give typically a verbal order to give it immediately.

So that's responding to a precise defined situation, where many of the others appear to be standing PRN orders.
Q. What are the problems with a standing PRN order for behavior-modification drugs?
A. Well, considering the problems that the drugs have as side effects, the PRN order basically means that the drug is being used and administered on the judgment of a non-professional, and certainly not a physician. That is the staff on the ward can make the judgment whether to give or not give the medication on a non-professional judgment.

BY THE COURT:
Q. What do the initials "PRN" stand for, if anything?
A. Sorry, Your Honor, I don't remember the Latin.

MR. FERLEGER: *Pro re nata.*

[3-44] MS. CHRISTENSEN: That's correct.

MR. FERLEGER: Which means as is necessary.

THE COURT: Say it again, I want you to say it for me.

MS. CHRISTENSEN: *Pro re nata*, Latin for as is necessary.

BY MS. CHRISTENSEN:

Q. Dr. Sprague, based on your professional expertise and your evaluation of medication factors at Pennhurst, in your opinion are excessive amounts of tranquilizing drugs being used at Pennhurst?

A. Yes, on the basis of the 51 percent of the residents receiving it; on the basis of the residents who are receiving psychotropic medication, 40 percent receiving polypharmacy; and on the basis of the length of time they are getting it; and on the basis of the very inadequate monitoring of the effects, they are being used excessively.

Q. Would you characterize such usage as constituting chemical restraints?

A. Yes. I believe that's the characterization.

Q. Doctor, you have mentioned some problems with the monitoring of behavioral side effects.

Why is this important? Why is monitoring important?

A. Well, it is like many other medications that are given for a reason and, if necessary, to see whether they are having an effect.

[3-45] Psychotropic drugs are given to control behavior and it is absolutely essential to see whether they work. Not all drugs work with individual residents. Not all drugs work at a certain dosage.

So if there is an adequate necessity to continue it, without monitoring the effects of these drugs, there is no way of ascertaining whether it should be given, whether it should be discontinued, whether the dose should be increased or decreased.

Q. Have you observed such an adequate and sensitive monitoring system at Pennhurst State Hospital?

A. No, I didn't. In fact, I observed just the opposite.

In my survey of the roughly 303 times medication was ordered, even counting where trite

phrases, such as "Behavior that I have referred to above," evaluation was only attempted 29 percent of the time.

Q. Is this a significant deficiency?

A. I would say most significant deficiency.

* * *

Supreme Court, U. S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

**ON WRITS OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

JOINT APPENDIX
VOLUME II, A386-A537

**Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.**

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

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**Qualifications of expert witnesses were stipulated pre-trial. Curriculum vitae designated as PARC and US Exhibits, detailing education, experience, publications and other qualifications of all plaintiffs' witnesses are found in the Final Pre-Trial Order filed at R. 464, March 31, 1978.

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[3-125] **Testimony of J. A. Lowrie**

BY MS. CHRISTENSEN:

Q. Mr. Lowrie, are you employed?

A. At the present time, yes.

Q. And where are you so employed?

A. At the Pennhurst Center at Spring City.

Q. And what is your position?

[3-126] A. A Mental Retardation Aide III, which is a first level supervisory position.

* * *

[3-130] Q. In your experience is the number of aides who are actually on duty on these wards a sufficient number of aides?

A. No, not at all.

Q. That is at the present time?

A. At the present time.

* * *

[3-141] Q. What happens after dinner?

A. After dinner they are brought back to the ward area and usually the aide staff will perform what is referred to as settle.

Q. Will you define that, please?

A. It means that they are taken into the bathroom areas, perhaps maybe, well, there's three toilet bowls in the bathroom area on that particular ward, so that they would be taken into the bathroom area and each of them would be given a turn to sit on the toilet; and after they are finished they would be gotten up and taken back down into the day room.

[3-142] Q. Have you ever actually observed this procedure?

A. Yes, I have.

* * *

[3-127] Q. Would you please state what your duties are generally?
A. Well, as a Mental Retardation Aide III supervisor I am responsible for making rounds at least once per shift of each of the cottages in the unit, writing disciplinary actions on the aides that are under me on the shift, keeping accurate time records on each of the aides, evaluating their performance and doing performance evaluation on them, doing monthly time schedules of each of the aides, where they will work and what their days off will be, and counseling them when necessary.

* * *

[3-128] Q. When you say children's unit, what age range are you referring to?
A. They would all be under 21.
Q. And approximately how many residents are residing now in Unit 5?
A. At the present time there's 105.
Q. Will you describe Unit 5? I guess Unit 5 is further divided into smaller subs; is that correct?
A. Yes. Unit 5 consists of six ward living areas.

* * *

[3-131] Q. . . . Is there a problem with time abuse with your direct-care staff?
A. Not a real problem. There is, I guess you have that anywhere — there is, I'd say out of the thirty people that I have that work for me in Unit 5 on the second shift, there may be about five that are what you consider time-abusers.
Q. And when you use the term "time-abusers" what is the number?

* * *

THE WITNESS: I am sorry.

I said that out of thirty people that are assigned to me on the second shift in Unit 5 there are perhaps five of them that might be considered time-abusers; and by "time-abusers" I am referring to someone who does not have time coming to them but takes off anyway, with not calling in, or continually takes a sick day in conjunction with two days off, or a holiday — definite patterns of abusing sick time.

[3-132] A. Well, not only does it throw off the ward's machine, but, for example, if you have a cottage where there's say, maybe sixteen hyperactive boys on it and they are used to having the same two or three aides working with them and for some reason somebody is abusing their time and doesn't show up, and you have to pull an aide from another unit or from another ward to work with that ward, when you throw somebody new into the situation not only do they not know, usually, how to handle the situation, but it also can affect the behavior of the children that they work with.

Q. Is there a high turnover rate among your direct-care staff?

A. Yes, there is.

Q. How high is the turnover rate, for example?

A. Oh, let me see. I would say since I began supervising, which was maybe about two years, I'd say almost the entire shift has been replaced, except for maybe four people that have been there through that period.

People are constantly coming and going. For instance, pregnancy leave of absence, people are let go because of poor time, maybe let go because of patient abuse — various reasons, transfer to another shift or to another unit.

* * *

[3-136] BY MS. CHRISTENSEN:

Q. Mr. Lowrie, in response to my question I asked would you please describe to me the physical characteristics of 11A. We can talk about where the boys are located later.

[3-137] A. O.K. C-11A, when you go into the entrance into the ward, the first room that you come in to is approximately 20 feet wide by maybe 35 feet long. It is a room that has blue and brown walls and brown tile floors and after you go through that room you make a right-hand turn and you come to a hallway which goes approximately, maybe it is 60 or 70-foot long hallway which has individual rooms on each side, and that's it.

That's what the ward looks like.

Q. Have you ever had occasion to visit this ward at or near the beginning of the second shift?

A. Yes, I have.

Q. And what time would that be?

A. Well, the shift starts at three, but by the time I am finished what I have to do, getting the wards and units covered, I could never really get to the ward until perhaps maybe 4 or 4:30.

Q. Could you describe for me from your own knowledge what the residents are doing at that time?

A. O.K. From the time they get back from school, which is approximately 2:30, they come on to the ward and there is a mat — the room that I described that you walk into first, which would be what I guess you would call a day room — there is a mat on the floor and there is large foam-filled play-therapy equipment that is called a doughnut.

Usually the boys are sitting on the floor. There is only one mat, so maybe three of the boys could fit on

[3-138] the mat. The rest of them would have to sit on the floor.

There's a couple of molded plastic chairs that they could sit on and they usually sit in that room and wait until it is time to take them to the dining room to eat.

Q. How is it that you know that they are sitting there from 2:30 until time for dinner?

A. There have been times — as I say, it is not regular routine that I would be on the ward very early, but there have been times when I have been there maybe a quarter after three or 3:30. I have been on the ward at different times from 3 to 11:30 and that's what they usually are doing.

If the weather is very nice and we happen to be lucky enough to have three people on the cottage a couple of the boys might be outside for a walk to get some air, but usually they are on the cottage until dinner time.

Q. And only a couple of the thirteen or fourteen residents?

A. Yes, because some of them are just too hyperactive. If you took the whole group out and you just had two staff members with them, there is a very good likelihood that one or two of them may run away.

Q. Would that be due to the insufficient number of aides to properly supervise them?

A. Yes, yes.

THE COURT: Let me interrupt you.

BY THE COURT:

[3-139] Q. Did I understand you to say that they would have returned from school at about 2:30?

A. About 2:30 is when they arrive back.

Q. Do you know where they go to school?

A. At the Liberty Forge School in Phoenixville.

Q. What type of school is that?

A. It is an intermediate school.

Q. And what type of supervision, if you know, do they receive at that school?
A. I visited the school several times with the unit director and they have a classroom in the school. They have eight or nine children in it, a teacher, and perhaps two teacher-aides; and the entire time that they are in school is just structured periods where they actually are being taught something or play therapy.
Q. When you say it is an intermediate school, who makes up the pupils at that school? Are they all from Pennhurst?
A. They are not all from Pennhurst. There are some retarded children from the community.
Q. This is a special school in that respect?
A. Yes, sir. It is not in the mainstream of the public school. It is a special school for us, for the retarded children.
Q. The thing that gave rise to my question was that you said when they returned from school, generally speaking, only two of them could go outside —
A. Yes.
[3-140] Q. — because of the few attendants and I was just wondering why, if they had been in school with a few attendants they couldn't all go outside with the attendants.
A. Usually, I say the classroom may consist of eight or nine children who probably like very much to go to school because they are getting out of the institution, they are getting a nice bus ride to school, they are sitting in a nice bright classroom, they have people working with them who enjoy working with them and are doing good constructive things with them, and it is a reinforcing situation for them.

When they know they have to ride back to the institution on a bus and get off and go into a drab ward where there is nothing provided to stimulate

them, this, I feel, really affects their behavior once they return to the ward.

* * *

[3-141] Q. At approximately what time do these boys dine?
A. At approximately 5:30 they are taken to the dining room.
Q. Do these boys all feed themselves?
A. Yes, they do.
Q. What happens after dinner?
A. After dinner they are brought back to the ward area and usually the aide staff will perform what is referred to as a settle.
Q. Will you define that, please?
A. It means that they are taken into the bathroom areas, perhaps maybe, well, there's three toilet bowls in the bathroom area on that particular ward, so that they would be taken into the bathroom area and each of them would be given a turn to sit on the toilet; and after they are finished they would be gotten up and taken back down into the day room.

[3-142] Q. Have you ever actually observed this procedure?
A. Yes, I have.
Q. Do the boys use toilet tissue?
A. No, they don't.
Q. Are they taught to wash their hands after using the bathroom?
A. No.
Q. Are there any programs being implemented on the wards to teach these self-help skills?
A. We have tried many times to develop self-help skill programs such as washing the face and hands.
Q. Are there any programs being used right now?
A. Not right now, no.
Q. Have you had occasion to observe the routine of the residents after dinner and after the —
A. Yes, I have.

Q. And what is that routine?
A. Usually they are just on the ward again, milling around or sitting on the mat on the floor, or perhaps one or two would be in the room with the T.V. set until bathing time, and then they would be showered, given their medication at 8 P.M., and then usually put to bed right after that.
Q. And that's it?
A. Yes.
Q. Were the residents in what is now C-11A always located in that particular ward?
[3-143] A. No. C-11A are the boys that were on what was referred to as Ward C-13.
Q. Could you briefly described why there were moved?
A. Well, C-13 was like a dungeon area. It was in the basement of the building. There were no windows where they could see any kind of daylight outside.

There were a few little windows around the top part of the walls, but they were only about perhaps a foot or a foot and a half wide and they were blocked off by a brick wall that was built for some new construction; so once the boys returned to that ward after school they didn't see daylight again until the next morning when they would go to school.

There was absolutely nothing on that ward that would be considered any kind of play equipment at all.

There were a lot of pipes that were hanging from the ceilings that I guess had water and electric wires in some of them, and there was wooden partitions built to separate the two bedroom areas from the day room.

It was just completely detrimental to the health of the children and provided no kind of stimulation for them whatsoever.
Q. How long were the boys left on Ward C-13 in that location?

A. Since some time in 1973.
Q. Moving next to Ward 25, have you had occasion to visit this ward on your rounds?
[3-144] A. Yes, I have.
Q. And is this the ward where there are at least two groups of children?
A. Yes. Ward 25, as I said earlier, has 32 residents living in the area.

There's approximately ten or eleven that are cerebral-palsy children and they are very high-functioning children. You can hold a conversation and they understand and they can let you know their needs.

The remainder of the children on that ward are small — smaller children than we have — males and females.
Q. Do you know a reason that these two groups of children are combined on that same ward?
A. If there is a reason, I have no idea what it is.
Q. Are there any particular problems combining those two types of residents?
A. Yes. We just moved into Ward 25 perhaps maybe eight months ago. Prior to that we were in D-1 and it was the same thing there.

They were mixed together. The bright cerebral-palsy residents had asked for a meeting with Dr. Youngberg and Dr. Meyers because they were upset about the fact that smaller children were either climbing all over their wheelchairs or throwing things at them or trying to knock them out of their chairs and they asked for a meeting to request their own separate dining areas.

There's problems having small hyperactive
[3-145] children in with people that are confined to a wheelchair. It is definitely a hazard.
Q. But they are still combined?
A. Yes, they are.

Q. Will you describe briefly what Ward 25 looks like?

A. Ward 25 is the hospital building of the institution. When you go into the entrance to the ward it is approximately forty or fifty feet wide. There would be like a hall area that you walk all the way through the entire ward, which is approximately the length of this room.

When you first go into this door there is a small room on your right. It is, I would say, maybe fifteen or twenty feet wide and about fifteen feet long.

In that room there is a mat on the floor and a couple of molded plastic chairs and in that room the smallest children on the ward are usually confined in that room from the time they get back from school until it is time for supper and then back into the room again until it is time for bathing and then put to bed.

Then beyond that room there is a small bedroom area that has six beds in it and a wall that comes up, perhaps, maybe five, four and a half feet high; and on the other side of the wall there's six more beds.

Then in the middle of the ward area is an office with windows on both sides; then two more bed-
[3-146] room areas, and then a small room at the other and similar to the room that the small children are confined to, and that small room at the other end is where the wheelchair residents usually watch T.V.

Q. Are there walls between the beds?

A. Not between the beds. There's like three beds here and then three beds with their feet facing each other and then small walls at the end.

Q. Approximately how much space is between each bed?

A. Approximately three feet, two and a half.

Q. There is no provision for privacy for that bedroom?

A. No, there is not.
Q. Is there a play area outdoors for the children who could utilize a play area?
A. There is a playground. If you go out the rear exit of that ward it has steps that go down into a playground area that has monkey bars, swings, sliding board.

But we have never been able to use it because, due to the fact that we have wheelchair residents on the ward, we felt that it was a hazard with only having the one entrance where we could come in and out of, and the far entrance has the steps that go down into the playground area.

We felt that in case of a fire there should be a ramp built at that back door so that we would have two ways of exiting from the ward area. It took quite a while before we got any kind of moving on that.

[3-147] Q. Is there a ramp there now?
A. No. There is a hole there, a large hole.
Q. Consequently, can the children get into that play area?
A. No, they would be falling into a hole if they tried to go out that door.
Q. Can they get to it any other way?
A. No. Three of the sides are closed off by buildings and the other side is a fence.
Q. Have you had occasion to observe the routine of the residents on this ward?
A. Yes.
Q. And is it essentially the same as the routine on Ward C-11A that you have described?
A. Yes, it is.

* * *

[4-179] BY MR. FERLEGER:

Q. Mr. Lowrie, I show you a document which has been marked Plaintiffs' Exhibit Number 56. This is

a six-page document entitled "Report on Present Conditions of Existing Seclusion Rooms at Pennhurst State School and Hospital," and I ask you if you recognize that document.
A. Yes, I do. I was looking for a date on the document.
Q. The document is dated January 8, 1975.
A. That's correct.
Q. At that time were you a member of the Behavior Modification Committee at Pennhurst?
A. Yes.
Q. And is it correct, as that document indicates, that you were appointed to head a subcommittee to investigate the conditions in the seclusion rooms?
A. That's correct.
Q. Would you please refer to the document, if necessary, sir, to refresh your recollection to answer these questions?

For that subcommittee, who made the tour and physical inspection of the seclusion rooms?
[4-180] A. I made the tour along with one of the other members on the committee.
Q. And did you go to every seclusion room at Pennhurst?
A. We went to every seclusion room that we were told was there, that existed at that time, yes.
Q. And what was the purpose of that inspection?
A. Well, there were several purposes.

We wanted, first of all, to see if the seclusion rooms that were in existence were adequate or — to make sure that there weren't anything in there that a resident who would be out in there alone and unattended might injure himself with; that there are sanitary conditions.
Q. Did you make a general physically inspection for any dangerous conditions?
A. Right, yes, yes.

Q. And were there any other purposes of that subcommittee's work?
A. We hoped that perhaps we could eliminate some of the seclusion rooms and if, in fact, some of them were necessary to keep, that they be brought up to some kind of standards and also the use of them be followed according to the standards.
Q. And is it correct that the last page of that document indicates that copies of your report went to Drs. Youngberg and Smilovitz?
A. That's correct; and the Safety Committee.
[4-181] Q. Now going unit by unit I would like you to describe what conditions you saw with your own eyes in those seclusion rooms.

Were there any seclusion rooms in Unit 1?
A. Unit 1 had no seclusion rooms at that time.
Q. Were there any seclusion rooms in Unit 2?
A. Yes.
Q. Describe those seclusion rooms and any dangerous or improper conditions you found there.
A. Okay.

In Unit 2 there was one seclusion room which was located off of Ward D-4. This seclusion room was also shared by the residents who were in Unit 6 or D-2, since they were in the same building.

The size of the room was approximately eight foot by ten foot. There was a screen on the door, which fits in a hole about that big with a screen on it, and the screen had sharp edges.

* * *

[4-183] Q. Will you speak about the seclusion room that you just started to describe?
A. May I read them?
Q. You may if you can first of your own recollection, as it may be refreshed by that document you have in front of you.

A. Okay. The screen that was on the window in the door did have sharp edges.

There was a radiator-cover that had sharp edges.

There was molding that was loose and sharp that could have possibly been torn off the wall and been used either as a self-abusive type of a tool or something like that.

This particular room also was on the second floor and there was a window in it and on occasion that window would be open, which also could have presented the possibility of the client being locked in that room alone and unattended and somehow breaking through that screen and jumping out the window to the cement below, which was a parking lot.

Q. What do you mean by open window?

A. The window would be open. There would be a screen on it, but actually the window itself would be open for ventilation.

Q. The only thing between the outside world and the cement ground and the seclusion room would be a typical window screen?

A. Yes.

Q. Not a security sort of thing?

[4-184] A. I really can't recall exactly what type of screen it was. All I know is it was a screen.

Q. Any other seclusion rooms in Unit 2?

A. No.

Q. Were there any seclusion rooms in Unit 3?

A. No.

Q. Were there any seclusion rooms in Unit 4?

A. No.

Q. How about Unit 5?

A. Okay. Unit 5 had a seclusion room that was right off of Ward D-3. That was located directly underneath the one that I have just described because that was on the upstairs.

Q. Any dangerous conditions you found there on your inspection?
A. Pretty much the same thing, like a lot of sharp edges on things that could have been used for self-abusive purposes.

That particular room also, as I recall, had a radiator in it which at times was hot.
Q. Mr. Lowrie, may I interrupt your description for a moment?

How long before the tour you took was the last inspection by Pennhurst officials or staff of all the seclusion rooms?
A. As far as I know, there was none.

* * *

[4-185] Q. Are there any other seclusion rooms in Unit 5?
[4-186[A. At the present time or then?
Q. As of the time of your inspection?
A. Okay. There was one seclusion on Ward 15, which was a wooden-paneled room that was in the area between the day room and the ward office area.

The problems that I recall that we saw in that seclusion room at the time — it was a wooden partition that had maybe a foot of opening at the top and maybe a foot of opening at the bottom; and also a window that was cut into the wood partition and it was big enough for somebody to stick their head through, and that was all.

We were concerned at the time that perhaps somebody could be in the seclusion and stick their head in the opening and not get it out, or also climb beneath the opening and not get out.

There was also a piece of electrical wiring that ran across the wall there that eventually led to a socket that could have been ripped loose from the wall, probably causing somebody to get a shock.
Q. The socket was inside or outside?

A. The socket was outside, but the wire that had the metal closure around it ran through the inside of the seclusion room.

Q. Any other seclusion rooms in that unit?

A. There was a seclusion room on M-3, and this was actually just another one of these rooms that
[4-187] may have been used as a bedroom but it wasn't. It was a seclusion room.

It had a heavy wooden door on it and again a hole in the door with the screen; and our concern, I recall very clearly when we were on the tour of that particular seclusion room, was that the radiator in there was extremely hot.

We found cigarette butts on the floor and a pack of matches in the closet that was in the seclusion room. The seclusion room had a closet in it and there was a pack of matches in the inside of it.

Q. Your tour was in the wintertime, I understand?

A. Yes, sir.

Q. Did you touch the radiator yourself?

A. Yes, sir.

Q. How long did you hold your hand on the radiator?

A. Not very long. Radiators in institutions, for some reason, are extremely hot. I don't know if it is the type of heat or what, but they are extremely hot.

Q. Okay.

Now the next unit. Would that be Unit 6?

A. Yes, Unit 6.

Q. Were there any seclusion rooms there?

A. There was three seclusion rooms — one in Building K-2. That was on the second floor of K Building.

Q. And K Building is now demolished?

[4-188] A. Yes, it is.

Q. Any other seclusion rooms?

A. There was one in D Building which I have already covered. That's the one that Unit 6 shared

with Unit 2 on the second floor of the D Building.
Q. Any other seclusion rooms in that building?
A. There was one seclusion room on H-2.
Q. Any dangerous conditions there?
A. Yes, there was. Again, this was a long narrow room I would say perhaps fifteen feet wide and maybe fifteen feet long and there were — again, there was electrical wires in there that were covered with metal and there was a radiator in there that didn't have any kind of protective covering on it at the time.
Q. Was this room built to be a seclusion room?
A. I imagine — well, it was made a seclusion room. It might have been a closet at one time but it was converted to be a seclusion room.
Q. Okay.

I believe we are up to Unit 7. Any seclusion rooms there?
A. In Unit 7 there four seclusion rooms, one off of Ward C-8.

I have got to really think on this because this was quite a while ago and I have to —

This was in Building — well, I could say it was
[4-189] around C-8. This again was on the second floor and it was a room that would not be situated in an area that could be very well observed, like it was a small room that was out in the hallway and then there was an office area over here and a day room over here, so it is quite — I remember discussing it with Dr. Hirst and the other people on the committee that we were concerned with the fact that somebody might have been put in that room and the aide would be in the day room or bedroom area with the remainder of the children and not be able to observe this seclusion room very carefully at that time.
Q. If you went up to the window of the seclusion room and looked in could you see every part of the room?

A. No, you could not.
Q. So the resident could be in a corner of the room where the resident wouldn't be visible?
A. Yes.
Q. Were there any other seclusion rooms in that unit?
A. In the C Building, one off of C-8, one off of C-7, another one off of C-6, and another one off of C-5.

The aide that we interviewed at the time said that the seclusion rooms off of C-5 and C-6 were not used as such. The doors were always left open and the client were allowed to go in that room and perhaps sit on the floor and be quiet, so it wasn't used, in effect, as a seclusion room.

Q. Any seclusion rooms in Unit 8?

[4-190] A. Yes. Unit 8 has a seclusion room. When you went in the front door off of the ramps or the walkway into Q-1 to your immediate right there was a seclusion room which would be the one for the boys in Q-1. I recall that very clearly because the smell in that room was unbearable.
Q. What kind of a smell?
A. From feces being smeared on the wall.

And there was also an air conditioner up high in the window, but it had been damaged quite a bit and there were sharp edges on it.

That room we were particularly concerned about from the condition of it.
Q. How high? Six feet? Five feet?
A. Sir, six and a half feet.
Q. Any other seclusion rooms?
A. The other seclusion room was on Q-2, which was on the second floor of Q Building, and that was similar to the seclusion room on C-1, very bad, smelling of feces and dirty, you know, like an animal shouldn't even be placed in a room like that. It was very bad.

Q. Did you inquire into how often the room was cleaned?
A. Well, no. I didn't, no. I don't recall.

* * *

[5-4] Q. We were talking about your survey and inspection of seclusion rooms.
A. Yes.
Q. If I recall where we were corrrectly I think you were about to describe seclusion rooms in Unit 8 —
A. Yes.
Q. — that you inspected.
A. Yes.
Q. Would you do that, please?
A. Yes.

The seclusion rooms in Unit 8, there was one located right inside the front doorway of Q-1, which was to the right-hand side after you entered the ward.

The seclusion rooms, that is, the problems we were concerned about with that particular seclusion room were that they seemed very unsanitary. There was feces smeared on the walls and the smell when you entered the room was very bad.

There was an air-conditioning unit in one of the windows that was sort of high in the air and there was an electric cord hanging down from that.

[5-5] Most of the seclusion rooms were in pretty bad disorder, like we felt that if seclusion was necessary that it should be an area that nobody could harm themselves in if they were . . . alone.
Q. Did your committee make any recommendations to the Pennhurst administration concerning seclusion?
A. Yes, we did.
Q. And what were those recommendations, and refer to your report to refresh your recollection if you need to.

A. Okay. The recommendations that we had made at the time were that it should be made clear to all the staff involved that if seclusion is necessary that it is not to be used as a punishment, but rather as a medical emergency where the person is required to be in a room alone until they have calmed down, and then should be left out.

We also recommended that a sturdy type of cabinet would be built, say right outside the door of the seclusion room, and in that should be posted the policy regarding seclusion and also the forms that would be filled out by the person who had put the person into seclusion, so that we would be guaranteed that this form would be filled out every fifteen minutes.

Q. Why was that necessary? Was there any problem with the policies at Pennhurst being followed?

A. Yes. There have been times where people were [5-6] placed in seclusion for an excessive amount of time.

Actually, as soon as a person is calmed down they should be given the opportunity to come out. We wanted to make sure that there was a guarantee that nobody would be left in seclusion for a long period of time without being monitored.

Q. Was seclusion used, did your subcommittee find, for the purposed of punishment of residents rather than for treatment?

A. Yes, it was. At times there were some clients that we had there that may have been considered delinquent-type clients and if they had gotten into some kind of trouble they would be put in seclusion for long periods of time.

There was one boy in particular who spent six days in seclusion.

Q. How long?

A. About six days.

Q. Continuous?
A. Yes.

* * *

[5-7] A. Now your recommendations went to Dr. Youngberg and Dr. Smilovitz, as you testified earlier.

[5-8] Do you know what, if any, action they took on those recommendations.
A. We never really got any kind of a reply at all as to what action was to be taken or would be taken. Our recommendations were handed in and we never heard anything about it.
Q. Were those sturdy cabinets built to post the seclusion policy?
A. No, they weren't.
Q. Mr. Lowrie, in your deposition you testified that for self-abusive residents, residents who bite themselves or hit themselves, a one-to-one therapeutic relationship is necessary to help them control their behavior.
A. Yes.
Q. Without the need for restraint or seclusion.

On what did you base that thought? On what learning or knowledge?
A. There has been numerous times — In Unit 5 we have some children that are hyperactive and we do have self-abusive behaviors.

I can think of one little boy in particular, Arthur, who has quite a bit of self-abusive behaviors, and he has some brain damage and he does become distrubed quite often.

I worked with Arthur quite a bit and I found that if I would perhaps sit him on my lap and just put my arms around the front of him and rock him for a while that would have a calming effect on him and eventually he would calm down.

[5-9] Q. And that's true of other residents —
A. Yes.
Q. — at Pennhurst also?
A. Yes, sir.
Q. And are there residents in your unit, in Unit 5, who would require such a one-to-one therapeutic relationship?
A. Yes.
Q. And are they receiving that sort of therapy in your unit?
A. No, sir.

Testimony of J.A. Flueck

* * *

[4-24] In the PARC Exhibit 48 you get a number of demo-
[4-25] graphic tables, tables that are background tables on the composition of the sample.

You see the sex, male-female, break out. You get the ethnicity, White, Black, Hispanic.

You get the age breakout, and you will notice on the age the average age of the people in the sample was roughly thirty-six years. That is the mean.

The median is also given. If you recall your high-school algebra, or if you didn't have high-school algebra your statistics in college, the median is simply that value such that fifty percent of the observations are less and fifty percent greater, so it is again another measure of the mid-point or mid-location of the assembled data.

As I understand it, this sample mean of about thirty-six years agrees fairly closely with a mean which was given by — what? The State — a day or so ago in an exhibit. I think they gave thirty-seven or something like that.

MR. GILHOOL: Your Honor, in the proposed findings of fact from the Commonwealth, they asked that the fact be found that the mean age, the average age, at Pennhurst was thirty-seven.

THE WITNESS: Table 4 gives age at entry and what you find out is that some entered very early in life and others a bit later.

The average age of entry is about fifteen years.

[4-26] Table 5 gives years at Pennhurst and what we find out is that roughly twenty-five percent of the people have been in Pennhurst ten or fewer years; twenty-five percent have been in essentially ten to twenty-one years; fifty percent have been in more than twenty-one years, and that last quartile, if you would like, twenty-five percent have been in thirty-one or more years.

You get the distribution, if you like, there on the column heading "CUMULATIVE PERCENT." You get the distribution of the number of people, if you like, or the percent of people who have been in a number of years, so on the average what you have is something like twenty-one years in residence at Pennhurst and with the indicated distribution.

Table 6 gives the most recent mental-retardation classification on the basis of IQ and so there you see the division under the five categories.

Something like around twelve percent are either mild or no MR and something like fourteen percent are moderate and so forth on up, the largest category being the profound. Roughly forty-eight percent are in the profound category.

The same classification was attempted on the basis of the adaptive behavior and there again you see the results and they are somewhat similar to the results of the IQs. They are slightly different but the proportions seem to be somewhat similar.

[4-27] Then, of course, the information on things like epilepsy, cerebral palsy, blindness, and deafness follow, and you can quickly glance at the proportions there.

As I understand it, it is not unusual to find that with mental retardation go a number of other diseases or a number of other problems, and you can begin to see that the percentages for epilepsy, for cerebral palsy, and so forth are very substantial.

Finally, we come down to mobility, Table 12, and there you find that roughly seventy-four percent are mobile and if, in fact, you add mobility, also assisted by devices, you roughly have about ninety-three percent. Only around seven percent are not ambulatory.

Table 13 gives us the dimension which we talked about earlier on communication, in other words, the presence or absence of family contact within the last three years —

Sorry, my mistake. I jumped ahead.

Table 13 is communications, how does the patient communicate; and roughly seventy-two percent use verbal measures and so forth, fifteen gestures, and twelve percent no communication.

Table 14 is the family contacts and this is the presence or absence of family contact within the last three years. Something like about fifty-seven percent had contacts and about forty-three percent had no contact.

* * *

[4-31] We are now getting to the measures of social disability or social accomplishments.

Table 21 gives you the year of the oldest Vineland.

Now remember, we started out with ninety-nine pa-
[4-32] tients in this data, this data base, and now we are going to be looking at only those patients which have both an oldest and newest, namely, two or more Vineland reports, so we are going to be looking very shortly at a change between the oldest Vineland and the newest Vineland, some measure of the change of the patient's social competancy or social disability or social functioning.

On Table 21 you simply have the distribution of the years. In other words, 2.1 percent of the patients had their oldest Vineland, namely, their first Vineland that's in the file, in the year 1940. 8.3 percent had it in 1951, and so forth on down, and 10.4 percent had their oldest in 1968 and so forth.

All right. Table 21B, which is an accompanying table, now is the measure which most of the experts feel is the best measure using the Vineland. It is a measure of the social competency or the social disability.

* * *

[4-33] Table 22 is the year of the newest Vineland, and that number is still for the subset of patients or

clients, clients or patients, who have had at least two Vinelands, the newest and the old one.

There you see the newest. You see the higher percentages toward the more recent years.

You would expect that because this is the year of the newest Vineland. All right.

Table 22B — here are your social-quotient scores based on the newest Vineland, and there you see that the data range from a score of 7 up to a score of 51, and here the data are somewhat symmetrical.

We see that the mean and the median are very similar. The mean is the value of twenty and the median also is roughly a value of twenty, so the suggestion is that this sample is pretty much symmetrical. All right.

Then let's go to a very important measure, and that's Table 23, the last table in the handout.

[4-34] This is now looking at each one of those forty-eight patients and saying let's take the difference between their newest score minus their oldest score, and that's what that column headed "Difference in Score" is.

There we see the range of differences from minus fifty points to plus ten points and there are the percentages. All right.

Well, what do we see? We can look down below and then come back. We see that on the average the patient for the period from the newest Vineland to the oldest Vineland lost about seven and a half points over his stay in Pennhurst, with a median of about 6 — six and a half points. This is a loss and if you put it on a per-year basis to the accompanying table, 23B, you get roughly around a little more than half a point loss per year per patient for each year you are in Pennhurst.

If you look at the column headed percent you will notice that we have drawn a line here at zero.

All of those scores above zero show either a loss in social quotient or no gain, so roughly around eighty-eight percent or 87.5 percent have a loss in their social quotient, a loss in their social competency; and the corresponding have a gain.

* * *

Testimony of Derek Lancaster-Gaye

* * *

[4-68] MR. GILHOOL: Your Honor, Mr. Lancaster-Gaye was qualified in a stipulation in pre-trial conference as an expert in the care and treatment of mentally-
[4-69] retarded people and in the management of residences and services for mentally-retarded and for the severely disabled people and is well versed in the history of such matters across the country.

DIRECT EXAMINATION

BY MR. GILHOOL:

Q. Mr. Lancaster-Gaye, have you visited Pennhurst?

A. Yes, indeed, I have.

Q. When?

A. On the 19th of March.

Q. And how long was your visit?

A. Between nine and ten hours, roughly.

Q. What parts of the institution did you visit?

A. It was a wide search of the hospital. I certainly visited, I find it difficult to tell you where.

Q. Did you form any impressions of Pennhurst State School and Hospital?

A. Yes, quite a number.

Q. And what were they?

A. I think I left with the unshaken feeling that Pennhurst was very much an institution like other institutions around the world.

One was left with the feeling — my visit was on a Saturday and one would expect Saturday to be quite a different day from the rest of the week and I guess one would not expect to see the usual range
[4-70] of facilities being provided on a Saturday but something in their place.

So to that extent I sensed that there was a lack of activity in the hospital.

I was struck, I think, by the poorness of the buildings themselves, which is a typical characteristic of institutions, many of which have been built, indeed, much longer than Pennhurst itself.

I was left with a feeling that the buildings — the hospital, the institutions, the whole complex — produced a sad and very real lack of stimulation for the people who lived there. It was very drab. The entire environment was such that it didn't create the sort of atmosphere which would produce stimulus.

I was struck, I think, by the fact almost evidently that there is a sense of isolation about Pennhurst. It is out in the wilds, as it were, and this is again, I think, a typical characteristic of institutions generally, and it is something that tends to rub off, indeed, on the patients.

I also left with a feeling, perhaps incorrect, because my visit was only for a short period of time, that there was almost no prospect of discharge of residents from the hospital itself, and I suppose I would base that feeling on the fact that this was an attitude conveyed to me by some of the staff to whom I spoke.

That is not to say that they said to me there is
[4-71] not much prospect of anybody getting better and going home. It wasn't that sort of thing. It was the feeling one had from talking to staff that there was a feeling of no such possibility about the future or certainly so much of the staff.

Finally, I would get that same reaction from some of the records that I saw. These records suggested that many of the patients had, in fact, been in the hospital for a very long time and one wondered to what extent there was, in fact, a chance of discharge.

Finally, I suppose having to settle on the one remaining impression I took away was a positive one rather than a negative one, your Honor, and that was that I was very struck and very impressed by the quality and the enthusiasm and, indeed, the devotion of many of the staff. This was very striking.
Q. Mr. Lancaster-Gaye, what effect do you consider that these factors — the absence of programming, the poor buildings, the lack of stimulation, the isolation, the little or no prospect of discharge — would have on the residents and staff of Pennhurst?
A. I suppose the almost inevitable analysis of problems — depersonalization is almost in everyone's words, but in my understanding I would see that as a person who is subjected to community feeding, community bathing, community toileting, and few personal relations, with nowhere to go, nowhere to go to have a cry, if you, in fact, feel that way — you
[4-72] are depersonalized and that's what I mean in that context.

So far as the isolation is concerned, one senses that the fact of isolation produces a lack of opportunity, particularly lack of opportunity to use some of the skills that one has already learned. One may well have reached the point of being relatively toilet-trained, and with inadequate toilet facilities the training is knocked out.

The opportunity to learn to speak, particularly in those with a physical disability who have problems with speaking defects; the opportunity to use what little skills you might have acquired in learning to speak are somewhat offset by the almost devastating noise that exists in any unit of that size for mentally-retarded people, more especially in wards which are cold and bare and stark as, indeed, are many of those at Pennhurst.

One wonders to what extent one has ability to use the skills of playing roles and playing games, as

it were, when, in fact, there seems in many cases to be virtually no opportunity at all to engage in a game without the role or game being completely shattered and disturbed and interrupted by violence.

I suppose in the same manner one could say that there is lack of stimulus. The present situation produced what I would regard as a series of urgencies. If you have a lack of stimulus, and this
[4-73] comes obviously from having nothing to do and nowhere to go, it is very difficult to do with nowhere to go. This quite obviously produces almost inevitably regression and that, in turn, must ultimately produce a behavior problem.

Another effect, I suppose, is the fact that the very scale of Pennhurst — and we are talking, your Honor, about 1200 patients more or less — with wards of somewhere between forty and sixty patients, with a small number of staff on many of the wards at the same time — one wonders how it is possible, and I suggest it isn't possible except in very rare instances, at rare times, for the residents on any of those wards, in fact, to relate individually to members of the staff.

What chance has a severely-handicapped person got, in effect, turning to someone who might be a powerful mother figure, someone in the figure of a transfer, somebody who will help him achieve something and go to him with the expectation of getting some sort of sympathy, and we all need sympathy sooner or later.

I felt too that there was a degree of frustation on the part of the staff because many of the residents were affected by a place like Pennhurst. It must inevitably affect the staff.

With a unit of that size there must be a large number of staff of different types and it may be that I saw only one particular type of staff with one par-
[4-74] ticular type of attitude, but certainly those I saw left

the impression that there was a degree of frustration — frustration merely feeling that so little could be done that certain programs might well have been recommended, and frustration at getting those programs put into effect with the facilities and general methods.

Certainly, I think there was frustration on the part of the staff. Indeed, on more than one occasion the word regression was used, and I also saw it written, with the thought that one of their patients, in fact, go back instead of going forward simply because of the lack of stimulus.

I think one would expect too at the end of the day, if the staff stay there long enough, and I can understand that the turnover of the staff there was surprisingly low, that there must have been in some way development of a degree of atrophy.

In fact, in my work in the United Kingdom, one tends to refer to the attitude of the staff and resident who have been there for any length of time as in happy apathy, which is a state.

Q. Mr. Lancaster-Gaye, with respect to motor disability, what did you observe at Pennhurst with respect to residents with motor disability?

A. I suppose my observations as far as they were concerned were similar, except that there was clearly a lack of understanding, I think, of the rather
[4-75] special problems of motor disability particularly with regard to cerebral-palsy patients who were there.

I saw a number of CP patients in wheelchairs without the modifications to meet some of the physical and postural problems that they would have, and I believe that other witnesses made similar reference to that.

Certainly, on more than one occasion I saw spastic young people sitting on the floor in positions

which were quite clearly to their future disadvantage.

I also had the impression that due to staff shortages it was very unlikely that the relatively large number of children, cerebral-palsy children and other spastics, must have received a relatively little amount of physical therapy, certainly less than they would normally receive were they in a community facility which is geared to provide that sort of care.

* * *

[4-80] Q. Is it then your opinion that it would be beneficial for each retarded person to live in the community?
A. Yes. I have no hesitation in saying that, and in probably three separate ways:

The community already has a very large number of retarded people living in it.

The community already has a large group of
[4-81] parents who, one way or another, are determined to go on with the problem of caring for and looking after their own children, by that time perhaps adult children, as long as it is humanly possible from their point of view.

If a parent was given some sort of choice they would in many ways be apt to go on caring for them themselves. The fact of the matter is that many are unable to do so because the local support facilities which provide the backup services — the social workers, the home help, the facility for short-term care to give Mom and Dad a break two or three times a year, to take the handicapped member of the family away during a period of domestic crisis, when perhaps another member of the family is ill — these facilities are seldom, if at all, ever available; and given that they were it would be possible for far more people to stay in the community or to go back to the community whence they came in the first place.

I suppose the second approach is still a family approach, that is, if there isn't a natural family or a part of the family that is capable of taking that retarded person, and we have the alternatives of adoption and foster care, and this is in my view deeply appropriate for adult patients or adult people as it would be for the majority of people.

Then we have, of course, the alternative of group homes, family homes. If we haven't got a [4-82] family and if we haven't got another natural family with an adoption or foster basis, okay, then you create the family home.

I think a final point I would mention here, of course, that we are all talking about actually when we talk about disabled people, about people who are disabled, to that extent the retarded person not only has the problems that retardation produces, but unhappily he has all the same problems that everybody else has because they are people; and when people tend to grow up they tend in many cases to decide that their moment has come and, in fact, they don't want to go on living with their parents and they want to move on to another sort of situation.

I would hate to think that we might be creating a situation which we perpetuated with the young person remaining at home and becoming a middle-aged person with parents who, simply because of their devotion, probably felt that they have got to go along in the absence of a suitable alternative.

Q. Why, in your opinion, is it beneficial that such retarded person live in the community?

A. Sometimes, I suppose, the answer seems so obvious that it is difficult to know where one should actually start.

It is, after all, the community that produces for us the things that we have, the life that we enjoy.

[4-83] We can't describe what it means about the community that means something to us individually. We do that regularly.

We decide when we want to dance, we decide what we are going to do or what sort of clothes we are going to wear. We decide what suit we like and what suit we don't like and it is nice to have some likes and dislikes and to be able to exercise them.

The important thing is to have the opportunity of actually saying no, I don't, or no, I won't, or I would prefer.

These are things that we tend to take for granted. The opportunity to do many things that love has to offer. This is the community, and it is a little difficult to imagine why any particular section of the community, whether they have had retarded people, disabled people, or any other sort, should not have equal opportunities to enjoy it.

So I submit, if ony for that person, the community is the right place for people to be.

But more scientifically, perhaps, and more clinically, I would have thought that the community, if, by the community we mean smaller units, if we mean units that are scaled down to the sort of facility —

THE COURT: Let me interrupt here just one second and ask you,

BY THE COURT:

[4-84] Q. What do you mean by the community?

A. By the community I mean a place where people live, where other people live, where it is all happening, where it is going on, where there are homes.

A community could well be a small village, it could well be a large one like Philadelphia.

It is merely where the people who happen to be in the area happen to live.

I don't think there is any restriction upon the size in relation to this particular argument but, as I was saying, I think it is the developmental side that is important.

I believe very thoroughly if one is to benefit, if one is retarded and one is to benefit fully from the opportunity to develop, then this happens more easily in a more stimulating way in the community and in a stimulating environment where there can be such things as individual attention, where there can be relationships and a relation between the retarded person and the people who are trained by some sort of contact and care, where there can be an improved quality of interaction between people who live together.

Q. In your opinion, is a home or a residential type house, I will say, in the community preferred to a small type institution that you have referred to of a couple hundred people?

A. Oh, yes, yes, yes.

[4-85] I mean I happen to be a person who believes that an institution is always an institution and that you can spend a lot of time and effort painting an institution and making it more comfortable, increasing the number of staff and so on and so on; and at the end of the day you have got a slightly more comfortable life if you look at that institution, and you haven't really changed the things that matter, which are the things that, in fact, enable the residents of the community to develop.

Do you see the point, sir? It is a very relevant point which I'd like to come to later on.

THE COURT: Yes.

BY MR. GILHOOL:

Q. Upon what is that opinion based, that opinion, namely, that small residences in the community

are, in the way that you have indicated, more beneficial to retarded people?

A. Well, this is, in fact, based on three things. It is based on empirical evidence, empirical studies that have been undertaken, upon the comparison of nations generally, and upon my own personal professional experience.

Q. What empirical evidence is there that the quality of life and the development of retarded people is better realized in small community residences than in institutions?

A. Really, we can push the United Kingdom again. We do have some.

[4-86] There are people who I think are quite internationally known — Jack Tizard, and Albert Kushlick. Jack Tizard, I know him very well. He is Professor of Special Education at London University.

He holds a professional chair which is funded by my organization. He is, in fact, chairman of the Retarded Educational Committee and I think he is pretty widely known in the field, and certainly in the United States as well.

Albert Kushlick is a doctor who was on the Regional Hospital Board when, in fact, it was a regional hospital board.

Q. What is it now?

A. Area Health Authority.

Q. That is to say, it provides both institutional services and community services?

A. Indeed, yes; and, indeed, the Department of Health for a long time in the United Kingdom decided to change its organizational structure in an attempt to do away with some of the boundaries that separate or the barriers, if you like, that separate some of the professional care in the field.

My organization was closely involved with the Kuchlick experiment too in the sense that we have

evolved to the degree that we paid part of the (?) and that provides a lot of these agencies.

I have some notes on these two pieces or se-
[4-88] verely-retarded children again.

Well, each unit was rated by the same observers, using a scale which at the time was known as the it had the terrifying name of the Inmate Management Scale, which is interesting because some years later, when he did his next survey, the name of the same scale had, in fact, been changed to Child Management Scale, and it had become humanized.

They have used these scales to measure the ways in which the daily lives of the residents in the institutions were, in fact, spent.

The outcome of that was that the hospitals, that is to say the institutional units, shared one pattern and the hostels another, despite the differences of the nature of the residents within the two groups; and the conclusion that was drawn from that particular piece of work was that it was the nature of the environment itself, that is to say, hospital or hostel, rather than the nature of the residents, that really accounts for the difference.

Ten years later Tizard decided that he would become a little more scientific and do the thing in an even more extensive way and he chose sixteen units as distinct from the initial six, and all of them were serving mentally-retarded people.

Five of those units were hospitals and eleven were hostels.

[4-89] Q. What are hostels?

A. Hostels are small, family-sized units in the community, relying on community facilities rather than having built-in services, with a minimum of staff, of course.

Q. What were the effective sizes of the five hospitals and the hostels?
A. Well, the hospitals varied up to about 600 patients. The hostels went down to, I think, the smallest hostel was ten residents; but within those two extremes there were quite a lot of variances, of course.
Q. What was the smallest hospital in the survey?
A. The smallest hospital, I think, was 300.
Q. And the largest hostel?
A. The largest hostel was 41.

All the children in those hostels were between the age —

No. In all the units that were part of the experiment were between the ages of five and sixteen. All had an IQ of 50 or less.

The significance of the 50 or less is that the United Kingdom's definition of retardation or severe retardation is 50 or less, so we refer to that as subnormality.

He produced a slightly amended scale of measurement which, as I say, has now changed its name to Child Management rather than Inmate Management; and again he dealt with determining the everyday life activities.

[4-90]

Now, not surprisingly, I suppose, the findings were not dissimilar. The findings were, in this case, that the hospitals produced a regimented and unstimulating result whilst the hostels produced a stimulating routine that would seem to be flexible and a lot more individual, where there was a fast-improving attraction between the residents and the staff.

The conclusion again was that it was the environment, the hostel or the hospital, rather than the residents themselves that made up the difference;

and he drew or considered as significant the fact that the better units, that it to say the units which had more flexibility, more individual care and attention, the things which one would assume would contribute to the development of the child, were, in fact, to be found in the smallest of the units.

Subsequently he complemented this with a study of five social and structural aspects of the institution and again two quite different patterns of care emerged.

One was orientation toward the residents themselves, whilst the other was oriented towards the institution; and the principal factor, he felt, that contributed to this result was assumed to be the organizational structure within the units themselves.

The size of the various units seemed to have little bearing on the results other than except that the
[4-91] best the doctor found was in the smaller areas, but this was not scientific sampling, nor did the degrees of handcaps or the nature of the handicaps appear to have any real bearing.

The view then was that an institution with 200 residents would be as institutionally-orientated as one with a thousand.

I think it is worth saying, although he didn't say it in his words, that the philosophy behind the concept of institutional orientation, child orientation, that he used, were, in fact, taken from Erving Goffman who I think is fairly well known locally, who held that management practices in hospitals, and I suspect that any of us who have worked in hospitals will not altogether disagree with this — are more in improving the organization than in trying to improve service and well-being for the residents.

An example of that philosophy quite simply is one I might suggest a conveyer approach to toileting

or bathing. If you two members or staff in a large ward and you have sixty patients to bath, this is done on a conveyer-belt principle. You take them toward the bathroom and you whip them in ten at a time.

This is directly for the convenience of the hospital because it is easier to do it, but it does do damage to the dignity of the individual.

[4-92] Unfortunately, the philosophy also tends to fall down a bit because that is not necessarily the best solution, for one member of the staff to have remained in the ward and amused the remaining fifty-eight or fifty-nine, and the other nurse might more effectively and efficiently the one child being bathed.

This is the Goffman theory as to the institutions and, certainly, the criteria that were used —

BY THE COURT:

Q. Would that be an explanation as to why they, in hospitals generally, come in and wake you up at five-thirty in the morning and say now is the time for your pill and your bath?

A. Yes, indeed.

My next comment was that inflexibility is certainly an example, and inflexibility is something which is seen when something has to happen every morning at the same time in the course of an institution, at nine-thirty every morning, because somewhere it is written that that happens.

That's the institutional approach and the same thing can be said very much of hospitals where bathing time is at a certain time, getting up is at a certain time, and where an individual would do better by either dining in the morning or having a special time for food or by doing something different than the masses, but which, to do that would create staffing problems and some other problems, and

that is quite clearly seen at the same time in the in-
[4-93] stitutions which Mr. Goffman visited.

Perhaps I could also say that happily at the time that Jack Tizard and his colleagues, Grey and King, were supported in a quite unpromoted way may be a group of people — McCormick, Balla, and Ziglar, who numbered an American, a Swede, and a Dane, I believe.

They used exactly the same scale as Tizard did in his research and they did their research in the United States and in Scandinavia and they were, in fact, really doing the same thing.

They looked at large institutions and very small ones. The very large institutions included some larger than a thousand patients, a thousand residents, and the lowest around a hundred residents. That's at one and of the scale.

At the other end of the scale they took group homes, smaller group homes that we have been discussing, where the largest group was around sixty patients and the smallest was around ten.

They too found striking differences in the care practices that were observed in each of these institutions and they discovered that the largest institutions were those characterized by the most institutionally-oriented practices and, of course, the small ones were those with the most resident-orientation care practices.

[4-94] Again, the type of institution, let us say, was a normal hospital. This was a consistent finding and in all the small hostels, again the care practices were consistently demonstrated and they came to the conclusion that their findings were precisely those of Tizard in his earlier two attempts.

Perhaps I could also briefly refer to practical operational research activities, if you like, which are very relative. First again, undertaking by Tizard,

known as the Brooklands Experiment. Here he simply removed from a hospital environment — it was a hospital in Epsom, quite a largish subnormality hospital, very much of the Pennhurst type, the sort of type that I described earlier.

They were all severely retarded and they were removed from quite clearly what was seen as an overcrowded environment and placed in a small hostel and at the same time a control group of young people were matched.

They were children who remained in the hospital and they were matched for intelligence and physical handicaps and sex and age as far as it was practicable to match children of this sort.

After a period of two years there was a comparison between the two and the results, I think, seem to be significant. It was found that the verbal scores of the children who had gone out, let us say the experimental children, had increased very significantly above those of the children who remained in the hospital and, generally speaking, those who were outside seemed to have progressed and developed more than those in the hospital.

[4-95]

The other experiment is somewhat more dramatic and somewhat more exciting. The Wessex Regional Hospital Board, as it was then part of the Government policy — decided that it would review the whole of the services of the region. Wessex is part of the south of England, and they decided they would review the whole of the services with a view to seeing to what extent additional provisions for subnormal people were needed. I say additional provisions because there is and has been a waiting list for hospital care of subnormal people in the United Kingdom for a very long time, largely on the basis that local authorities have been slow or had been at that time to develop community-based facilities.

The hospital board was to decide just what was needed, but they decided to do it in such a way that instead of discovering that they needed more beds, these beds provided in hospitals, they were doing it in such a way that the places were to be provided in the communities themselves.

They decided to set up and, indeed, did establish five hostels, again of the type that I have been talking about. These are, in the Wessex case, units of around twenty or twenty-five places.

My own organization became involved in the
[4-96] first of those with the purpose of the hospital authority. This was, in fact, a converted premises. In fact, I think two of the five were in converted premises, namely three were converted units.

All, of course, were provided or designed on the basis of a domestic atmosphere. This is an attempt to recapture a normal family feeling and the patients who went into these units were selected on the basis that they represented a realistic cross-section of ages among children, as they talked about children, or in adults, if they were adults, who would produce at least a group of people who might be expected to get on together very mildly.

These individuals had certain choices or certain opportunities to choose with whom they were going to live. What is significant is that one of those hostels, one of the adult hostels, was provided with the object expressly of taking the most profoundly-handicapped and behavior-disordered people that could be found in the local hospitals.

A second was developed on the basis that it would cater to the behavior-disordered, non-ambulant children from the hospital group; and the three adult units each took mixed groups, and what I mean by mixed groups is that they included children mildly retarded, profoundly retarded, a complete mixture.

[4-97] This was now done and after about two years there were attempts to measure the improvement that might be expected to take place, and there was ample evidence that the skills of all the patients had improved in relationship to their everyday activity, e.g., eating, table manners, washing, toileting, speech, and things like appropriate general behavior as opposed to inappropriate general behavior, and emotional response.

At least half the children in the children's hostels now go back home every weekend and they attend the hostels only five days a week. This has the obvious attraction that it enables parents and the retarded children to maintain an important link, perhaps in expectation that in time to come the children may go back and live at home permanently.

If the success of a development of this sort is measured by the number of residents who haven't made it, then I think in the first four years of the development there were three children, only three, out of something like ninety, who had to be sent home — I am sorry — sent back to the institution whence they came and for reasons which one may well argue, whether valid or not valid.

I do recollect that one of the children went back because he was a persistent biter, and biting affect was something that was more effectively dealt with, it was claimed, in the institution.

[4-98] Well, the records are interesting in the fact that they also record the fact that when he got back to the institution he went on biting. It didn't actually make any difference to him.

Three adults, I think, over a period of time were sent back to the hospitals whence they came, again for behavior disorders which were difficult to contain; and I think one honestly felt that he wanted to go back.

But that is six failures, if you like, six incorrect initial placements, which means that overall that particular scheme has been a profound success.

In answer to your question, I am sorry, it has been a long answer, those are the sort of empirical things on which one would like to base the value judgment that people are better off in the community.

BY MR. GILHOOL:

Q. In addition to the empirics of the matter you said that your opinion was based also on the effective effect of community residence and institutions on retarded people, it was based also on comparative international experience.

Will you tell us what that experience shows?

A. I have already mentioned that I have been to a number of countries and have studied the systems and I thing it is fairly general that over the past five or ten years countries, certainly in the western world and certainly those that are more advanced, have recognized the fact that community care is to
[4-99] be preferred to institutional care.

Whether those decisions on the same assumptions that we have made, whether they are based on the same criteria is of less significance, I think, and certainly most countries have produced a policy of let's get back to the community and let's stay in the community.

Some have managed to do something about it, some have not. Certainly, countries like Sweden, Denmark, the United Kingdom, the Netherlands, France, and even — not even, but Italy have managed to go some way in producing a return and certainly there are signs that hostels are springing up.

In Italy, I might say in one city, the City of Milan, they did a very brave thing. They said as of a particular date no handicapped person shall live in

an institution, no handicapped person shall go to a special school for handicapped children. Everyone from that date will go along with everyone else.

A very brave decision and the result of which one would like to have a look at in the years ahead because it does tend to presuppose that segregation is something that happens when you press a button and it comes; but nevertheless it is a way of achieving it and I think they probably get tired of waiting and said this will happen and, certainly, it has happened.

BY THE COURT:

[4-100] Q. Who made that statement in Italy?

A. Happily, in this case, the local authority in Milan made this decision, aided and abetted by all the professionals who had done their thinking about institutions.

* * *

[4-101] BY MR. GILHOOL:

Q. You said that your opinion about the respective merits of residence in the community and institutions is also based upon your own professional experience in the choice between institutional and community service.

What has that experience been?

A. Well, over the years we have engaged ourselves in a number of studies. We have undertaken or been closely involved in three studies of this precise problem.

* * *

[4-106] Lastly, the last two of those studies have now we are going to take an interest in your unit because you built it in our community.

Then we went through a difficult period, which necessarily we are always going through, in which we were acutely short of cash, and this dictated that

we should try to do something to maximize the use of the premises that we had got and it wasn't really until we started to see — it is terrible to go back — that one does these things, but it isn't until you have done them that you realize how wrong you were.

Then we tried to see to what extent it was possible to put more patients or more residents into the premises that we got in the thought that this would at least maximize the use and limit the expenses.

We never did it, fortunately, because it was during that particular period of time that we got the first of our reports that I mentioned earlier from the Institute for Research, which quite clearly came out with the normal cry, which said there is something called quality of life; and the studies have tried to perfect what that meant in practical terms and how we could, in fact, provide an improved quality of life.

And it was said to what extent can the resident themselves of the institutions that we had, because they were institutions at that time, be expected to know what was best for them. It is very dangerous
[4-107] because if you are in the situation of providing for disabled people it is very easy to fall into the trap of actually imputing to disabled people what they want without actually knowing what they want.

You merely think they ought to want it because we all like it. Although we tended to impute it to them, and we spent much time therein, nevertheless, finally, to answer your question, the end result was that if we were going to change the quality of life it seemed from the studies that we got, from the conversations that we had with residents and, indeed, with ourselves, that this meant smaller and smaller units.

So the change that has taken place over a period of twenty-four years in that sense has been the abandonment of larger units and replacement by

smaller ones and as a final stage of this we are currently going through the fairly early purposes and I hope we shall establish it as a fact early next year because we have started to build already. We are even beginning to abandon the smaller family units in place of even smaller dwellings, apartments, I guess you call them here, flats, for groups of two or four people.

Q. In your opinion, what is the optimum size of residence for severely and profoundly handicapped people?

A. In my view I think that would be around eight or ten and even that's a fairly large family.

Q. Would you then recommend as a solution to the conditions at Pennhurst the provision of such facili-

[4-108] ties in the community, alternative living places for those there?

A. Will you repeat that?

Q. Would residential facilities of that sort then be your recommendations to remedy the conditions at Pennhurst?

A. Oh, certainly, it would. Yes, it would.

Q. Why not improve Pennhurst? Why not increase staff and staff-patient ratios, reconstruct the buildings, or even divide Pennhurst into three 400-person institutions or four 300-person institutions?

A. There are two reasons, I would suggest.

The first is back to gospel. You have an institution that is, in my belief, such that there is no way in which you are going to change the end result. It is always going to be an institution, whatever you do to it.

Certainly, you can spend money on it but I would suggest it would be money very unwisely spent.

More logically, I would think the immediate answer to that question is what we all know that the

community has more to offer than an institution, so why jack up an institution if, in fact, disabled people can benefit from the community.

Q. If the choice is so clear in terms of the growth and development of retarded people and in terms of the quality of their lives, why do we continue to have institutions, and you testified we have them across the board?

[4-109] A. It is right that they are there and I suppose a large number of those institutions have been there for a hundred years or more. Those are monuments and monuments don't get torn down very quickly.

They were put there in the first place, I suggest, because the population had a fear of retardation. They didn't know what retardation was all about.

It knew that it had a commitment and felt that the commitment would be met if it built these places in the countryside.

Generally speaking, and I am sure this is true of Pennhurst as well, they are employers of people. There is, in some measure, a reluctance to destroy something that cannot be replaced.

But generally speaking there is a very substantial investment in a unit of that sort and I think an understanding reluctance to cancel one's investment in that sense.

Some countries have problems not unlike the ones we have in the United Kingdom. I haven't the slightest doubt you have your own particular version of this problem, and that's the problem of funding.

We have no one set person that pays for everything, only the members of the public.

THE COURT: I think we inherited that.

[4-110] THE WITNESS: In the U.K. the hospital service is paid for nationally. We pay for that out of our income tax, the revenue that we get from that.

The lesser authorities are responsible for a variety of community services in some manner and we pay for that as ratepayers.

Now I think it is a fact of life, because there is an enormous no-man's-land in which it is nobody's responsibility because there are claims that the recipients or the theoretical recipients could be the responsibility of the others, that one is the obligation of the other.

The fact remains that the hospitals are funded from one source and community facilities from another.

There is a difficulty, and we have experienced it ourselves, if you attempt to persuade the local authority to take out of the hospitals people who come from its area but who live in hospitals, in the knowledge that they will be a charge upon the rates. Then this is quite a different matter.

All the philosophers and the moralizing suddenly disappear because somebody has actually got to pay for them and, of course, it is very easy to refer a potential patient from the community to the hospital because it is cheaper — not because it is cheaper, in fact, but because it is cheaper for the ratepayers of the area because they don't have to pay for it.

I think those are factors which tend to perpet-
[4-111] uate the institutions.

BY MR. GILHOOL:

Q. Why do parents continue to use institutions?

A. Why not? In the majority of cases there is simply no alternative.

If you are a parent of any retarded person, if you have struggled with that person for some years, if you have got a family of your own as well, and if you get to the point where you are not going to go on any

longer and somebody says we will take your child, there is that instant feeling of relief.

You are not, in some cases, bothered where it is going to be. If a social worker leans on your shoulder and says, "Don't worry, we are going to look after Fred," you believe the social worker and the social worker may well say "Don't worry" through gratitude because she knows that the only solution at that moment in time is incarceration in an institution, and she may realize, though, that she has done it before but when that parent pays his or her first visit to that hospital they will never go back again or that they will take their child back.

Q. Is smallness by itself sufficient for the quality of life and the growth and development that you have spoken of?

A. Smallness is an awful long way but there is no way in which you are going to get the right answer if you don't plan it in advance in the right way.

[4-112]

Smallness is a vehicle which will provide the things you want, but I suggest if one is going to go small, if one is going to have hostels in the community, one has to sit down and think about it and decide how they are going to work.

One of the objects of the exercise I suggest is that we might try to achieve something we call integration. Integration is a slightly intangible thing and it could well be that we all understand something slightly different by it.

But what it is in its recognition by the community is the fact that there is somebody, some group of people who are there; and you recognize that they are there and you recognize that they have a right to be there. That's integration.

Integration also means that the people we are talking about have the opportunity to do the things that everybody else in that community has — no

privileges, no appliances, and none of the offices — just the plain chance to do the same thing, the chance to go to school like other kids, the chance to go shopping like other people. That's integration.

If you are going to attempt to get integration certainly, in this day and age and certainly, in the United Kingdom, you have to think so.

Could I mention an example, indeed, to illustrate the point?

[4-113] We were trying to persuade a local authority to do the very thing that we were discussing just now, that is, to recognize the fact that there is a large group of handicapped, retarded people in hospitals who shouldn't be there because hospitals are for sick people and these are not sick.

If they come from a particular area there is no reason why they shouldn't live in it, so how were we going to put a hostel in the community that was going to be run by the local authority who was going to accept the financial responsibility for doing it?

In such ways the children were not merely transferred from one institution to another, not less restricted, but at least an environment that was limiting because people would say oh, that's where the disabled people live; and that's not right.

In this case, it was in the seaside town of Eastbourne in Sussex. We organized with the then East Sussex County Bar, the Eastbourne-Sussex County Council, and we arranged to be provided for a site in the middle of a new housing site that was going to be built.

We talked with the architect of the entire housing site and we developed three or four — four, it was — units of six in buildings which were architecturally, externally, identical to all of the other buildings. They had their numbers in the street and they looked exactly like the others, all of

[4-114] which was acceptable.

[4-114] What happened in the back was another thing. What went on in the front was one thing; what went on in the back was another.

So it was relatively certain that the state had certain accesses and thruways which went through our property, the development, which would get people through. We arranged it so that there was a play area; the play park and things were actually immediately adjacent to the development so all the kids from the estate could at least come to this particular play area where the handicapped children were going to be anyhow.

We involved in terms of staff the people who lived on this estate, so that they make up, I think, three-quarters of the staff of the unit.

These are married persons with no particular skills, other than looking after children, looking after children of their own. Those that have young children of their own bring their children with them when they come to work and they play and the older ones go to school.

This was two years ago and two years later I think I can only say that because it was planned, because more or less all the residents came onto this site within the same limited period of time, nobody who came would turn around and say what right have they got to be there.

[4-115] It just happens that they got more people. The bus comes every morning and takes the handicapped children to school in the same bus.

BY THE COURT:

Q. Do they go to the same school?

A. I was about to say that, indeed, they go to the same school. We have arranged that all handicapped children, retarded children, go to exactly the same school as all the other children.

It might have been necessary in some cases to adapt the other facility. In the case of the school it was, but this was quite an easy way to do it and I think it is fair to say that integration is taking place.

We shall try to measure the reaction of the community after a period of a couple of years, but I don't think it is going to be necessary because they are so involved already, the result is a complete acceptance.

This is just an anecdote of what I meant really by not trying to do something in spite of everything, but getting down and trying to return people.

We do, as an organization, have a role in trying to secure the integration of people. If ever we had a particular hook on which to hang a hat, I think we would choose the integration one.

It covers so many problems, particularly with retarded people, and we are very closely involved in
[4-116] the United Kingdom in something I think you have too. It is a one-to-one organization, the object of which is to relate the members of the public to a handicapped person in the hospital, a retarded person.

In the United Kingdom ours is fortunately growing at the moment. We very recently had a television appeal in which we had a two-hour program in which we asked for 3,000 volunteers in certain parts of the United Kingdom to come into hospitals and to establish, in fact, a one-to-one relationship with a resident, where the function would be to meet them at the hospital to take them shopping, converse, talk to them, write to them, do the sort of thing that a friend would do.

Within — well, I think within two hours there were 7,000 who responded. It was very dramatic.

BY MR. GILHOOL:

Q. Does this relationship exist between people who are residents in the group homes in the community and, if so, what is their function?

A. Yes, they do exist and their function really is twofold because the function is a useful function.

People need to have access to the community and it may well be that the more retarded you are the more personal help at that sort of level you are going to need, particularly during the period of getting used to the community, so it has a very practical value.

[4-117] Also, there is a useful built-in value, that is a safeguarding factor. Whoever has the responsibility of running the organization, who are all volunteers at the moment, you can very quickly tell from the moment if he is going to blow his top. You know that something is going wrong inside and that's another useful reason for having him.

MR. GILHOOL: Thank you, Mr. Lancaster-Gaye.

I have no further questions.

[5-91] **Testimony of F. Girardeau**

* * *

Q. In your opinion is the environment, staffing level, and level of program such that each resident has reasonable opportunity to be habilitated?
A. They do not have a reasonable opportunity to be habilitated at Pennhurst.
Q. In your professional opinion does Pennhurst provide each of its residents with a minimally-acceptable program of habilitative care and treatment?
A. No. It definitely does not.
Q. Indeed, is it more likely an environment where people will lose skills?
A. Yes. In institutions like Pennhurst it is not only that you don't develop, it is that you get regression of skills.

People come in with difficulty with language systems, speech. As a function of having to keep the noise level down in large wards you don't talk for years, you don't have interaction with results, so your speech regresses.

Furthermore, one of the worst things about the large institutions, understaffed, is that you seek maladaptive behaviors, that is, you seek self-abuse, you teach people to abuse others, you teach severe aggression, so it is not only that you don't develop, you regress and then you learn maladaptive behavior.

So it is not just not developing, it is that you are
[5-92] getting worse, you are learning to abuse yourself, to pick at yourself. There is nothing else to do there so you can see this in situations where you put people in crowded areas.
Q. Is it then your opinion that Pennhurst is a failure in keeping each resident free from harm and injury?

A. I don't think that Pennhurst is keeping people free from harm and injury. They are not, from my observation.

Q. Could you describe for us what it is about the total environment which you view as destructive in the end of habilitation?

A. Well, there's three major factors about the total environment that are destructive.

First is the physical environment, the physical layout, the buildings, the wards, the training areas, so to speak.

The second aspect of the environment that is destructive is the lack of adequate staff to manage and supervise, to provide basic custodial care.

The third is the lack of staff training, that is, even if you have large numbers of staff, unless they are well-trained and continually brought up-to-date on these things that are happening — new developments in the field of mental retardation — unless you have a continual training program your staff still are not going to be able to handle it.

[5-93] So it is basically three things in the environment — physical environment, lack of staff, and the lack of staff training.

* * *

[5-111] Q. In your opinion what are the consequences of the lack of habilitative programming which you described and the destructive environment which you described at Pennhurst?

A. As I said earlier, the consequences of this are either no improvement in development or growth, either staying where you are or regressing.

The third consequence is you learn and engage
[5-112] in maladaptive behavior. You learn it and you have plenty of time to do it because there is nothing else to do.

Q. Will you describe for us what you mean by maladaptive behavior?
A. By maladaptive behavior I am referring to self-abuse — fires set, self abuse, in which people bite themselves, pull their own hair, pick at sores, head-banging. This would be self-abuse.

And then another form of maladaptive behavior is the stereotyped behavior — sitting and rocking all day long or going like this all day long, just stereotyped behavior.

Another type of maladaptive behavior is severe aggression against other people. Either ward mates or staff.

Those are the three big areas, the three most frequent areas for maladaptive behavior.
Q. In your experience under what conditions do these behaviors typically arise?
A. Well, you get maladaptive behavior arising primarily when there are four factors present in the environment.

The first factor is overcrowding. The second factor is the lack of materials, the lack of opportunities to learn, that is, no magazines, nothing to read, no training activities.

So you have overcrowding first, a lack of materials and activities; third, when there is present aggressive behavior occurring by others or maladaptive behavior, you learn to imitate from the other people and this is a fairly common way of learning aggressive behavior — you see it occurring by others and imitate it.

[5-113]

The fourth factor is that frequently maladaptive behavior is rewarded, either by adults' attention or giving the person something; so when you have a situation where there are large numbers of people that you are trying to supervise, most times the supervisor will only pay attention if there is some maladaptive behavior, so the person who gets rewarded socially is engaging in maladaptive behavior.

When those four factors are present you will usually find you will get a great deal of self-abuse.
Q. In your opinion are those four conditions present at Pennhurst?
A. Yes, they are all four present.

* * *

Q. Now from your review of the seclusion and restraint records, U. S. Exhibits 39 and 40, were you able to ascertain the incidence or the frequency of the use of seclusion at Pennhurst?
A. Yes, the general frequency of it.
Q. And how would you describe the frequency?
A. It is fairly common. It occurs, I would say, fairly frequently.

With some individuals it is much more frequent than with others. Some people, from the records, are placed in seclusion maybe five times a month and other people are placed in seclusion almost daily. In fact, there is at least one case in which the person spends ten to eleven hours each day in seclusion.
Q. Were you able, from the review of these records, to get an idea of the duration of the time the person spends in seclusion, however frequently or infrequently they go into seclusion?
A. Yes. There were time periods of three and four hours in seclusion and, of course, there was a great range.

Sometimes a person was placed in seclusion for only fifteen minutes, but it ranged up to, in one case, eleven hours in seclusion on a single day and it was repeated the next day for ten hours and the next day for ten hours.

But generally speaking the time was about one
[5-126] hour, one to one and a half hours; but there were instances, as I said, of fifteen minutes and some of three or four hours.
Q. From these records, U. S. Exhibits 39 and 40,

were you able to ascertain the incidence or frequency of use of physical restraints.

A. Yes.

Q. And how would you describe the frequency of physical restraints?

A. The frequency was much higher than seclusion, meaning occurrence of people placed in restraints every day or every other day, and it showed, the frequency of restraints, also that great deal of variety, where some people could be restrained on maybe three or four hours out of a month and other people would be restrained almost every day, so there is a lot of range of frequency.

Q. There was a lot of range also in duration of time of physical restraints?

A. Yes, approximately the same as seclusion. Generally speaking, it would be in the neighborhood of one to five hours in the physical restraints.

Q. Could you describe generally what physical restraints are?

A. They use camisoles. I think that was described to the Court the other day.

You put the hands in a heavy cloth kind of coat, but you put it on backwards and your hands, you put them around like this and they are tied at the back.

[5-127] They use muffs, hand muffs, wrist shackles, ankle shackles, face masks, halters, and a couple of others I don't recall right now that they used.

Q. From the records were you able to ascertain the reasons physical restraints were employed at Pennhurst?

A. Yes.

Q. Can you describe for us the reasons you found for it in the records?

A. Most of them were self-abuse or abuse to others.

Other things that I noted in the records, they were used for "agitated, yelling, destructive", and then, as a I mentioned, self-abuse and abuse of others.

Q. Do these reasons lead you to believe in your opinion that restraints were being used at Pennhurst for punishment?
A. It seems that in some cases, yes.
Q. Do any of the reasons you have outlined, your opinion, constitute sufficient reason to employ physical restraints.?
A. Yes. There are, on a temporary basis, until programs are developed, people who are abusive to themselves, physically abusive to others, who will have to be restrained until they can be rehabilitated or habilitated.
Q. In your opinion, with efficacious habilitative care and treatment would the incidence of the use of physical restraints perhaps be reduced at Pennhurst?
A. With the proper programming I think it would
[5-128] drop dramatically and I think the witness testified that that was, indeed, the case.
Q. What would be your view or opinion ordinarily that such devices should not be employed?
A. They should not be employed as far as the treatment goes.

They should be employed for protection — protection for the person from self-abuse or protection for other people — but should not be considered a part of the treatment scene.

They really have been shown to decelerate or get rid of the behavior, so they should not be used for treatment, but they might be used for protection until a treatment plan was developed.
Q. Are there, therefore, potential hazards with the use of physical restraints that make the use of them potentially dangerous?
A. Yes. The hazards are that the person is frequently taken out of other activities and not engaged in constructive activity.

With restraints too we found, at least in a recent year-long study in North Carolina, that some people will, after being in restraints for many years, really engage in maladaptive behavior to get put into the restraints.

So you have a situation where you can get some adult patients, you can get some adult attention if
[5-129] you do something wrong and, indeed, get put in restraints.

They found that restraints, indeed, functioned in that manner; in other words, they were positive reinforcement for maladaptive behavior, so that's one of the dangers.

I think you have to analyze the situation in each case very carefully to make certain how the restraints are functioning. You have to do a very close analysis and see what's happening.

Q. Would that suggest that when they are employed careful monitoring procedures should be used?

A. Yes, very careful monitoring procedures.

Q. The techniques that you have described to decelerate the occurrence of maladaptive behavior leading to the necessity of seclusion — are those techniques also applied to getting rid of, if you will, the behaviors that cause the need for the physical restraints.

A. I am not sure I understand the question.

Q. You described for us a number of behavior modification techniques which you said were effective in changing maladaptive behavior.

Other ways to decelerate the behaviors in lieu of the employment of seclusion, would these techniques that you described also apply to declerating the maladaptive behaviors that create the need and cause for the use of physical restraints?

[5-130] A. Yes. The same procedures could be used to get rid of those behaviors that led to the restraints; on occasion, yes.

Q. In your opinion are those techniques effective for such use?

A. Yes.

Q. And are they commonly accepted by professionals across the nation?

A. Yes, quite commonly accepted.

[5-134]

* * *

Q. In your opinion would Pennhurst ever be able to, given again the optimal conditions, offer adequate habilitative care and treatment programs to each individual resident?

A. No. I think they could get rid of the maladaptive behaviors, but I don't think they could provide the developmental growth, the developmental training that is necessary for them to be rehabilitated.

Q. Would you explain?

A. Well, you get rid of the maladaptive behaviors and always you replace it with behaviors that are useful for living in a community.

You just have someone who is not doing anything, but you could develop treatment plans at Pennhurst, but they are still isolated from the community and if a person earns them, or, well, let's take earning — if you were to earn some money there is no place to spend it.

You might develop a scrip but it would still be different from the stores in a community.

If a person went to purchase groceries and learned to cook his own meal, they wouldn't be able
[5-135] to provide stoves for everyone to learn to cook. You would have two or three stoves for all of the adults.

Even though you might cure the maladaptive behaviors, you need the community programs to teach the normal Pennhurst behavior in the community and if you don't do this at Pennhurst, largely isolated from the community largely due to people being congregated in one place, they just don't learn well in such a situation.

It is better to have them out with normal people so they can learn from them.

Q. Is it your opinion then that Pennhurst would have difficulties and that it would be practically an impossible task of trying to provide normal life settings for retarded persons?

A I'd say it is impossible to do in that large an institutional situation.

* * *

[5-137]

BY MR. PEABODY:

Q. Are there settings which, in your opinion, can
[5-138] most appropriately be used to habilitate retarded persons?

A. Yes, there are.

Q. And are these the normalized settings you have been referring to from time to time?

A. Yes, all throughout.

Q. Have you toured various community based mental-retardation programs in various communities in Southeastern Pennsylvania?

A. Yes.

Q. Could you tell us what programs you have visited and what programs were evaluated?

A. I visited programs in Delaware County, Montgomery County, Chester County, and Philadelphia County.

Q. And when did you visit these programs and facilities?

A. March 2nd, March 3rd, March 4, 1977.

Q. And could you explain how you conducted your evaluation?

A. Yes. I toured the facilities, made observations as to the programs.

I interviewed staff and I looked at some records.

Q. Did you talk to people?

A. Yes, and I talked — yes, I talked to retarded people themselves.

Q. What is your opinion as to whether all of the programs you visited are offering an adequate program of habilitative care and treatment?

[5-139] A. I found all of those that I visited — in the programs I found all of them to be offering adequate habilittion.

Q. I believe we have neglected to list the programs and facilities which you visited.

Could you list those for us?

A. Yes. I remember most of them.

I visited the Elwyn Day Development Center in Springfield, Pennsylvania.

I visited the Keystone Learning Center in Boothwyn.

I visited the Delaware County ARC work Activity Center in Lansdowne.

I visited apartments operated by community Interaction in Drexel Hill.

I visited some apartments in Delaware County that are supervised by Elwyn Institute. Those were in Clifton Heights.

I visited the Lynch Home in Willow Grove, Pennsylvania.

I visited the motivation program that is operated out of the Montgomery County ARC in Norristown. I visited Center Square School, which is a public school in Norristown, Pennsylvnaia.

I visisted the Rivercrest Center in Mont Clare.

[5-140] I visited St. Christopher's Hospital here in Philadelphia.

I visited but did not look at the programs, but I visited with the principal at the Hill School, which is in Germantown, here in Philadelphia. That's special center for trainable retarded children.

Then I visited the apartments and discussed the program in West Chester with the Chester County Association for Retarded Citizens, and I visited come apartments there in West Chester.

Q. And this tour lasted for three days?

A. Yes, and some nights. I mean we were visiting in the evenings at some places.

Q. Why was it important to visit some programs during the evenings?

A. Because the people were at work during the day and they were back in the apartments during the evenings, so we wanted to visit when they were there.

Q. You mean the retarded citizens?

A. Yes.

Q. Did the programs available cover the necessary continuum of services necessary to meet the needs of these retarded persons?

A. Yes. They covered the whole continuum from two months old retarded infant up to older, in their fifties, sixties, seventies; all types of mental retarda-

[5-141] tion from very profound, very profound with medical problems, up through people who were mildly, just mildly retarded, so it covered all ages, all types of programs and all levels of mental retardation.

Q. Could you describe the continuum of services available?

A. Yes.

The infant motivation program in Norristown is operated in a church basement doing — Sundays it is used as a nursery school for the church. This was a program for twenty children from birth to three

years of age. The youngest one there at the time was two months of age.

They had profoundly retarded, bed cases, so to speak, that had multiple handicaps, very young.

It covered social development, language development, motor development, development of cognitive or intellectual skills.

It worked with the parents. The parents had meetings. They counseled parents, worked with the parents.

These children live in their own homes, by the way. There were eighteen of them that lived in their natural home and two that lived in a foster home, but it is a three or four-hour program a day and they live in their natural homes.

They also have a program working with parents, in which they go into the parents' homes and work with the children and show the parents the techniques of developmental growth with their children. [5-142]

That's the program for the youngest ones.

Q. Was there a continuum available for the rest of the range of ages?

A. Yes.

Q. Could you describe just more briefly the kinds of services that are necessary to fill the rest of the continuum, if you will?

A. At ages three to five they usually provide nursery school and preschool and I think in Norristown I am told that now the public schools provide this.

The ARC provides it from August through June in pre-nursery school and then they need public-school education and some counseling and work with parents during school-age years.

Following school, in the later school years, high school, eight years, there is vocational training and

once they reach eighteen or twenty-one, I don't know, I am not certain in Pennsylvania whether the public schools provide education up to eighteen or twenty-one, but once they end at the high-school level, then you need vocational training, work placement, community-living arrangements, either in apartments or in small groups, homes, or with foster families; and you need that whole continuum of services.

Q. Is it your opinion that persons with all ranges of
[5-143] mental retardation can appropriately be habilitated in the community through the use of this continuum which you have described?

A. Yes.

With severe medical problems, profoundly-handicapped, serious physical problems, you would need to have medical services already available, but I think there are probably at least five medical centers in the Philadelphia area, so even for those cases, as in Omaha, Nebraska, one small wing of the Pediatrics Department, the Pediatrics Section of the Hospital is devoted to the profoundly bedridden cases and there they have available some of the best medical care available by having it in the medical-center area.

Q. You are referring to a community hospital in that respect?

A. Yes.

* * *

BY THE COURT:

Q. You said that in your tour of the counties — Chester, Delaware, Montgomery, and Philadelphia — you had observed various types of facilities for this care and housing that you preferred for individuals.

Could you describe one that you visited that may have been treating the profoundly-retarded who had physical handicaps? For instance, as you just mentioned, I think, they may have been bedriden or close to it?

[5-144] Did you tour any such community facility like that?

A. Yes, one.

Q. Where was that?

A. That was the Lynch Home in Willow Grove. They have twenty-three profoundly-retarded, and Mr. Lynch said of the very profoundly-retarded only one would fit above the notion of profound.

He had a large hydrocephalus, heavy brain injury, and communications like that.

They have twenty-three between the ages of two years and twenty-one years.

Q. When you say the Lynch Home, do you know any more about the background of the Lynch Home?

A. Yes. He was telling us that his mother and father had been operating it over years, and that he had maybe six years and it has been going for forty years.

It is just like your house or my house, just sitting there, no designation "Lynch Home for Retarded" or anything. There is just the mailbox.

There are profound levels there as you will find anywhere.

Q. Do you have any idea what kind of a staff they have there?

A. Yes. They have a nurse on duty twenty-four hours.

Q. Three shifts?

[5-145] A. Well, three shifts, three nurses, eight-hour shifts.

They have a program director. The public school for the school-age kids that cannot go out. I think eight of the twenty-three go out to public schools in some way. They might have to be picked up and carried, but they go out to public schools.

The other fifteen, those that are school-age, the public school is now providing a teacher. The intermediate unit is providing a teacher and teacher aides to come in every day from eight to four.

Then he also has a couple of staff that he pays for. The public school provides two teachers and he is paying the other.

* * *

THE WITNESS: I think I should mention there are also profoundly, multiply-handicapped at Penn Square School in Norristown. There were eight. Two of them are not all — in my interview with the teachers I asked them, you know, should these people in an institution. They are multiply-handicapped, the children not at all trained, and here they are in a public school.

And they said — the aide teachers said there is no way that these people should be in an institution.

[5-146] We can do the habilitative training here. They can get an education. We can work with the parents and they can remain in their homes.

BY THE COURT:

Q. What was the name of that and where was that located?

A. Penn Square School in Norristown on Germantown Pike. It is a public school and they have one wing of the school devoted to the retarded and there's fifty-six children there school-age.

Only eight of the fifty-six were profoundly-retarded with multiple handicaps and only two not toilet-trained.

Q. Where did they reside, if you know?
A. In their natural homes, and some in foster homes.
Q. I see. All right.
A. They were all in homes, family arrangements, not in group homes.

I interviewed the principal and she said no problem, they come and eat with the normal kids, the regular kids, and they have physical education.

But other than that, their academic day is separate. It is a wing of the school. It is partly integrated and partly not is the situation.

BY MR. PEABODY:

Q. Dr. Girardeau, I refer you now to Photograph Numbered 92 on page forty-eight and ask you if that's an accurate representation of a scene in the Lynch Home in Willow Grove, Pennsylvania, which
[5-147] you have just described to the Judge.
A. Page forty-eight?
Q. Right, Number 92.
A. The top of the page?
Q. The top of the page.
A. Yes, that is. That's the Lynch Home in Willow Grove.
Q. Can you describe what the photograph depicts?
A. There are children there, two, with extreme hydrocephalus. There is another child on the right side lying on the floor and the young woman working with the child near the fireplace is from the intermediate unit, as a teacher, a special ed unit, who works with the profoundly-retarded, and in this case I think she is doing some motor development training.

The ones on the left and the right were unattended but they were being worked with when we went into the home and the people moved back when we were taking pictures.

Q. In your opinion is that a normalized setting?
A. Yes, to a large degree.
Q. Is this setting an appropriate one to provide these individual retarded persons with a reasonable opportunity to reach their fullest individual potential?
A. I think it is if the numbers were kept low.

I personally would not like to see places set up with twenty-three profoundly-retarded all in one house. That's too many and the problems are great with that.

[5-148] Q. You prefer to see smaller numbers?
A. Yes, but at least this environment can be used even for the profoundly-retarded in what I am saying.
Q. Can you describe at this moment, not designating by name —
A. Right.
Q. Where was it located?
A. Located on the street, like the street where you live, just a house interspersed with other houses; an older house, but you couldn't tell it.
Q. A residence?
A. It was a residence, yes.
Q. Dr. Girardeau, I now refer you to Photograph 89 on page forty-six and ask you if that is an accurate representation of the infant stimulation program you described earlier in Montgomery County?
A. Yes, it is.
Q. And this is the basement of the church?
A. Yes.
Q. Could you describe what the scene depicts?
A. It is one of the rooms. This is the lower-functioning children.

This pictures a person working with a couple of real small youngsters about, oh, about a year old,

and they are doing various physical and motor activities with them.

There were some other teachers in there during the period of time but they are not in the picture.

[5-149] Q. Is this kind of program important in your opinion to prevent institutionalization?

A. Extremely important, to start early, at birth, and to work with parents, to work with children and the community, and it is extremely important to start at birth and not wait until programs develop later.

Q. Would you describe for us in more detail why early intervention is absolutely necessary?

A. Well, without certain skills you will never develop other skills. Before you can run you have to walk.

It is just that with early language development, early social development. Early intellectual development skils later on, so you have to have these basic prerequisite skills to be able to do the other things. If you don't get them you don't get the others.

Q. Were home-bound instruction and services related or conne ted with this program in any way?

A. Yes. They were working with eighteen families who had retarded children by going into the home and working with the children and training the parents in their activities.

Q. Can you explain the kind of activities that are taught in home-bound activities?

A. They teach the parents how to socially interact with their child, how to train them, language development, how to show them pictures and get them to

[5-150] name objects.

They train the parents in how to teach the child to feed themselves, toilet training, and the whole range of child development skills.

Parents are the best teachers. I mean they are with the children all the time and if you can train

the parents to do a lot of these activities they don't have to rely on large numbers of professionals.

The parents can do it. We do it for our children, so retarded parents will do it for their children.

They have problems and it becomes burdensome to them if they don't understand how long it might take or some better techniques, so the important thing is to train the parents.

Q. Are these services also important in preserving the family as the baic unit of living?

A. I think they are because in many cases it causes great family problems. A severely-retarded child, profoundly retarded, it is a strain on the family and without some help and some counseling it creates a problem for a large number, a large percentage of families.

So it is very important to have these kinds of services to maintain the family unit.

Q. Were severe and profoundly-retarded in this program?

A. Yes, severely and profoundly-retarded, very
[5-151] young, but profoundly-retarded.

Q. Dr. Girardeau, I now refer you to Photographs Numbered 90 and 91 on page forty-seven and ask you if they are accurate representations of various scenes in the apartments which you visited on Garrett Road in Drexel Hill, Pennsylvania, in Delaware County.

A. Before I answer that let me back up to the previous question for just a moment. I just want to be clear.

The infant motivation program also has some moderately-retarded and some Downs Syndromes, so they had a range from moderate down to profound; but a large number of Downs syndrome and moderate retardation.

Q. What is the Downs Syndrome?

A. The Downs Syndrome is a chromosomal defect in which the child is born with an extra chromosome and certain physical characteristics and this gives, in addition to these physical characteristics, short stature, eyes of a certain nature, a bridge of the nose, fissured tongue, a large tongue, frequently.

These kinds of characteristics are not present in all Downs Syndromes.

It used to be called Mongolism, what used to be called Mongolism. That term has been dropped and we now use the words Downs Syndrome for Dr. Downs who first described it in history.

Most of the children, most Downs Syndrome
[5-152] people, range from sixty to sixty-five IQ down to the low twenties, so there is a very wide range, but most of them are in the middle range of mental retardation.

Q. I now refer you back to Photos 90 and 91 and ask you if they are accurate representations of scenes in the apartment you visited on Garrett Road in Drexel Hill, Pennsylvania, Delaware County.

A. Yes, they are. One of them is the living room and one a bedroom in those apartments.

Q. Are these normalized settings in your opinion?

A. Extremely normal.

Q. Can you describe the use of these facilities, the nature and function of the program?

A. There were two apartments in just a regular apartment building, a duplex.

The apartment on the lower floor was a situation in which there were three boys living with house parents and they were in the school-age range and they were going out to school.

One of them in that apartment was also blind as well as retarded.

There were in the severe category, severe mental retardation.

In the other apartment, also house parents — in both cases fairly young. Turning back, they were
[5-153] about thirty, to be perfectly honest.

THE COURT: I agree with you. I think I go a lot further than you as to what is young.

THE WITNESS: Yes, I think so.

The top four are three girls and a boy. One of them is not toilet-trained. They are severe to profound.

We can't tell yet because there is a lot of education to be done, but out of the six it was reported to me that all of the parents were considering institutionalization at the time that this program became available, these apartments were set up, and they were all engaged in activities such as going on picnics, going shopping with the parents, horseback riding at the "Y" on Saturday, or arranged by the "Y"; going through a normal life routine with the house parents.

The house parents are paid. They are salaried professional people. Some are in college, some are taking additional courses to learn about mental retardation and so on.

We have a training program in Kansas to train house parents. They end with a Master's degree in Houseparentry, so we are doing more and more towards having professionally-trained, well-trained houseparents rather than just picking up people, you know, without any experience.

That's a new advance in the past five years.

BY MR. PEABODY:

Q. Is there mental retardation in these children of various ranges?

[5-154] A. No, sir. I think all of them were classified as severely-retarded.

Q. Now I refer you to Photographs 94 and 95 and ask you if they are accurate representations of scenes that you observed in the Keystone Learning Center in Boothwyn, Pennsylvania.
Q. Yes.
Q. In Delaware County?
A. Yes, they are.
Q. Could you describe for us what the pictures are depicting?
A. Photograph 94 was a group discussion. It was an educational situation in which they were discussing — I have forgotten — some past epoch of American history or something.

There were two teachers and I think there were six young boys, aged to twelve years of age, in this particular situation.

The Keystone Learning Center has eight boys and they are retarded with emotional problems, behavioral problems.

Their IQs or their levels are not down in the severe range, but they are up in the moderate-mild in terms of mental retardation.

But getting to this program, it is especially set up for retarded with severe behavioral problems so that the school system cannot handle them. This is
[5-155] set up on the Tennessee Model developed by Dr. Hobbs right after I left Peabody, in, oh, 1963. The boys come in on Sunday afternoon and they stay until Friday afternoon and they live with their natural parents or foster parents when they come in and it is a very tightly-structured situation for the fellows who have behavioral problems as well as mental retardation, so it is a very tightly structured training program.
Q. In your opinion is there any reason why various maladaptive behaviors in mentally-retarded persons cannot be appropriately handled in a community program?

A. They can be handled best in a community program, better than in institutions.
Q. Is that because of the model and learning, copying, if you will, a concept that you have outlined?
A. That's part of it; and then, where you have a ratio of — I think there are three staff members most of the time present for aid — you have a much better teaching situation with small numbers like eight boys and three teachers.

So it is not only this modeling, but also the size of the situation, the number of people congregated in one place.
Q. And Photograph Number 95?
A. 95 is where we are eating lunch. We ate lunch with the boys.

No problems.
Q. Was this a normalized setting in your opinion?
[5-156] A. Extremely normalized.
Q. Did the residents have the knives, forks, spoons, and the appropriate utensils to eat with and to eat from?
A. Yes.
Q. I now refer you to Photograph 94. Is it an accurate representation of a bedroom that you visited in the West Chester apartments in Chester County?
A. Yes, it is.
Q. Is privacy possible in such a setting?
A. That's a good example of a person having privacy, to have their own bedroom.
Q. In your opinion is this normalization?
A. Yes. It is an apartment building in an apartment complex, a large apartment complex, and it is just one of the apartments.

In Chester County the Chester County Association for Retarded Citizens operates both a preschool and a community living program for adults.

They have twenty-nine adults, some who live in group homes and some who live in apartments.

It is sort of a progression. If you have learned normal living skills in the group home you move out to an apartment, total independent living.

And I visited two of the apartments and this is one. They are both in housing projects or in housing apartment complexes.

[5-157] Q. Developments?

A. Apartment developments, just like probably where you live in Washington or Virginia.

Q. Could you explain to us why privacy is important to a retarded person?

A. Well, I don't think it is any more important to them than it is to us, but I think I mean that's one of the basic things we value.

You can do things and not be bassled by large groups. I mean you can read or listen to the radio.

When you live on a ward with forty other people, in a great big ward, you can't lie down in the evening and listen to the radio; some forty can't.

Maybe one can but the others have to listen to whatever you have chosen on the radio, so there is no freedom of choice in the large institutions and in an apartment you have a great deal of freedom of choice.

You can wash your clothes at night in the washing machine if you want to or go to a baseball game, so it allows a great deal of freedom of choice and from that you learn how to live.

That's the basic reason that privacy in these small situations is so important.

Q. What was the level of retardation of the adults living at this particular apartment development?

[5-158] A. Moderately-retarded in the middle range. I think two out of the three that were living in that apartment had been at Pennhurst, former Pennhurst

graduates, and I don't know how long they had lived at Pennhurst — quite a number of years.

Q. And they were now successfully habilitated to the point where they were able to live —

A. Yes.

Q. — in these apartments?

A. Yes, and one is in competitive employment, that is, fighting for a job in the job world; and the other one, I think is in a workshop or work-activity center.

But they all work during the day, either in a work activity or workshop or in competitive employment and fifteen out of the twenty-nine were in competitive employment.

Fifteen of the twenty-nine in the Chester County adult program had jobs, earning their money. They all had bank accounts, every one of them.

Q. And they were being taught money skills too?

A. Yes, how to purchase things on sale and all the things that he needs to know about financial matters.

Q. Now generally in the kinds of things you have just described, the goal for all returned persons is a job in competitive employment?

A. Yes, as an adult living and working and earning your way in the world, that's the general goal.

[5-159] Q. I now refer you to Photograph 93 on page forty-eight and ask you if it is an accurate representation of the Delaware County Association for Mentally Retarded Citizens Work Activities Citizens Work Activities Center, Lansdowne, Pennsylvania?

A. It is. It is a photograph of that center.

Q. And can you describe the purpose, nature, and function of the programs?

A. Yes.

This is for older retarded between the ages of twenty-one and thirty-two. I think that was the age

range of the sixty-six people who come to this center.

It is called a Work Activities Center. They are trained. The training occuring now involves learning to come to work on time, stay at your job; and the tasks they are using are similar tasks, and I think you will see in the foreground that they are assembling Liberty Bells, I guess they are assembling, and at least this particular persor is assembling Liberty Bells and it was reported to me that they get there on time, they are anxious to work, they work hard; and as they progress out of that they are referred to other, more advanced job training and hopefully eventually to seek competitive employment.

Some of them take the bus to and from the work activities.

Q. And where is the Work Activities Center located?

[5-160] A. It is in Lansdowne, in Delaware County, I think. I am not certain of my geography. I think it is Delaware; it is Lansdowne.

Q. Is it in an industrial park or a shopping center?

A. No. It is sort of on a main street in a residential area but, oh, you know, somewhat of a thoroughfare in a residential area; just about a block or two from the downtown area downtown Lansdowne.

Q. So it is located, if you will, in the mainstream of day-to-day activities?

A. Very definitely.

Q. What was the level of retardation of the persons in this program?

A. They went from severe, not from profound but from severe to moderate.

Q. Is this the kind of normalized work setting you would recommend for adult retarded persons based upon their individual needs and abilities?

A. It would be a first step, but it would only be a first step.

It is planned to get out here into more advanced work situations, but it is a necessary component in some habilitation programs.

We have to have this availability. There is some disagreement in the profession about whether you
[5-161] have to have the Work Activities Center. You might be able to have situations where you could go straight into a workshop or competitive-employment situation; but most professionals will have the work activities center in this stage of the development of the community programs.

Q. On their way —

A. On their way to competitive employment.

Q. Did you visit the Penn Square School in Norristown?

A. Yes, and I described that a few minutes ago.

Q. Which program was that?

A. The public school that had sixty-six children in a wing of the regular public school and there were eight that were profoundly retarded with multiple handicaps; and I asked the teachers should they be placed in institutions and they unanimously said no, they are dealing with the profoundly-multiple-handicaped in the community.

Q. Dr. Girardeau, of all the residents that you saw on your tour of Pennhurst did you observe any who could not benefit, in your opinion, through the use of the kinds of services and programs we have just been discussing?

A. Did I see any that could not benefit?

Q. Could not benefit.

A. No, I did not see any that could not benefit. They could all benefit from this service.

* * *

[6-3] **Testimony of L. L. Glenn**

BY MR. PEABODY:

Q. Miss Glenn, when we recessed yesterday I was about to ask you how the principles of normalization which you have described for us could be put to use in practical terms in community programs.

A. Okay.

Since both the continuum of services that are needed by individuals and the range of alternatives is different with children than with adults, I'd like to handle them separately.

First off, with children, I think it is important, within normalization it is important, to make sure that if a child in any way possible can remain in their own home they should do so. I mean with all the fancy programs that we have we certainly
[6-4] haven't found a substitute for the natural family and only in rare instances has it been necessary to take people out if appropriate services are available to the family.

Typically, there are only three reasons that a family would have to request an out-of-home type of service, one that the child would reside elsewhere.

That is a management problem with the child, the child may be growing older and larger and have physical handicaps and the family has trouble physically manipulating the child to bathe or to move around in a home that doesn't have adaptive appliances or ramps and that type of thing.

Or there may be a behavior-management problem. The child may have some behavior problems and they may need management assistance.

The second reason might be a real problem in the family. In that case the family may need assistance to keep the child in the home for the family's sake and not be a problem to the child.

The third is that not too often the children, the neighbors in the community, really don't want

somebody that has that many problems there to make a lot of trouble.

The most common, however, is the first — the family really have difficulty in different types of management situations with the child; and, unfortunately, as service has been provided in the past,
[6-5] we have only offered parents out-of-home services. We have only offered them or even encouraged them to seek institutionalization in places like Pennhurst, in a private organization, or even in community programs.

In some cases the situation exists that only an out-of-home group home or foster placement is given as an option to parents when, in fact, in most cases the families would like to keep the kids at home if the service is provided that such maybe a part-time staff member could be given to the family for maybe when the child is home from school until when they go to bed at night, from three to eight, to help that family learn to manage the child.

Or, if it is a very young child, some assistance to the family that I think we talked about earlier, in earlier testimony, would help them learn to work with that child and continue their development along the same continuum that any child would develop; or in appliances, putting ramps in the home so the child can use adaptive equipment to be able to navigate his own environment, but could not live in that house without some kind of adaptations to the house.

Other types of services might be that the family has two other kids and it is just hard to manage for a special child with special needs and to also work with the two other kids.

Maybe the family just needs a washer and
[6-6] dryer so she doesn't have to leave every day and spend three hours at the laundromat; or another part-time staff member, so that they can manage all three kids and keep the retarded child at home.

This has been very effective and most children can stay in their own home and not have to leave. In very few cases now where those services are provided does the child have to leave his own home.

In the day-to-day services we have learned a lot, both children and adults. In the past managers running home services have always, when they have identified a child or evaluated a child and found out the child had special problems, said, "Aha, that person needs a special program;" and they'd immediately take the child and put them in a group with other children that had similar difficulties or were also, you know, creating management problems.

Then you ended up with the same phenomenon which I mentioned yesterday of the child not really learning things that other children would learn because they are in a special environment and they are not given the same opportunities as anyone else.

This happened to myself. I used to teach regular education, eighth to twelfth grade and when somebody was sent to special ed class they automatically got arts and crafts instead of the developmental materials that other people had or the opportunities that other people had. It is sort of, you know, an automatic — well, kids who come to special ed class must be slower and we will give him, you know, the lower type of opportunities and materials to work on.

[6-7]

That's got to be reversed and I think it is being reversed. We are finding that if we keep kids as much as possible in the normal setting with the special supports, if necessary, that that child will learn to grow and learn to be with other kids much more rapidly or maybe not be allowed in another situation, so you would let the child enter appropriate programs that any children would enter, even if you have to provide some extra staff support or extra programming.

We have done this quite effectively in the

agency that I ran in Nebraska, where even the most multiply-handicapped children we put in normal preschools, if they were provided out-of-home services, and then we put a staff member right there, say, with four children in preschool as against thirty to thirty-five in normal school, and we would still provide the extra training with the extra staff member there.

But the kids would interact with all the normal kids and the normal kids could interact with the handicapped children also and we found phenomenal growth, even in those children that we had in our own programs that were segregated just for handicapped.

[6-8] Once they went in to a program with non-handicapped kids, the same behavior that they had been growing only slowly on in our segregated centers, they began rapid growth.

We kept a lot of data on different indices, like words spoken, sounds said, interaction, you know, interaction with teachers, initiated self-interaction with peers, different types of social behavior, other actual clinical indices; and some of it showed that within a very short period of time a number in the first six-months period with thirty-five children, some of their behaviors increased seven times above what they were actually doing in these skills when they were in a segregated situation.

So to the degree possible the children should be allowed to progress in the same type of settings with other children all the way through school and only taken out for special types of training when that was necessary for them, and it might be along that continuum that some children should participate only in certain types of activities with non-handicapped children, such as their normal recess times, such as their normal recreation or their art time or their music time, that is not developmentally or academically demanding on them.

We also found that the normal kids love it. It is another old myth that the non-handicapped kids will not accept the handicapped kids.

[6-9] My theory on that is when you get them at preschool level or at first, second, or third-grade level, we have gotten the normal kids before their parents have prejudiced them about handicapped kids to where they are not accepted.

Some children moving along that continuum really progress well. They are accepted. It is nice to see the non-handicapped kids really accepting the handicapped kids and allowing them to participate in the communities. With adults, different types of services are obviously needed. It is not normal for an adult to remain in their natural home. And adult needs to get away from the protective environment of the home and to start learning, developing his own social friends and activities.

The most important thing with adults is to really separate out the four areas of an adult's life. There are really four areas in adult life — the residential, the domiciliary, the developmental activity, whether you are still in education or have gone into recreational-vocational training, the recreational areas, we all need to recreate; the other social areas, whether it be going to church, shopping, taking transportation.

The unfortunate thing about institutionalization is that we attempt to protect all four of these areas of a person's life when he may only need training and assistance in one or two. A person could live

[6-10] by himself, but he needs vocational training, some kind of skill training. He might be able to hold down a job to assist him living in the home, but he doesn't know how to budget, how to cook.

He doesn't even know, if he earns the money, how appropriately to budget and spend that money, or may be able to live independently and work in a sheltered workshop independently without other as-

sistance, but he may have trouble using his leisure time or learning how to do the navigation stuff like transportation, shopping in the stores, comparing the shopping in the stores, and the whole range of independent living skills.

So for each of these areas we have to look independently at these areas and not try to shelter all four because there is a problem in one of those areas, and that's what an institution does.

In the residential areas we try to have the person in a most normal setting. We would not fit him in large groups.

In fact, I found that even running a large community-based service, if you got groups of adults larger than seven or eight adults the group started to become inwardly oriented and didn't reach out and make other social contacts. They were stuck with those seven or eight people and that was almost as bad in some cases as having them in the larger groups.

[6-11] You try to have the person in a situation where he is with his peers. He doesn't necessarily need a family model any longer, but maybe a college student that is living with, say, two mentally-retarded adults, a part-time college student that only needs to be there maybe in the evening, to help over the dinnertime.

Or if he needs more structure you might have a full-time staff member that's there al the time that's living with them. Then it would progress to more and more structure depending on the needs.

He may have problems, other social problems, from individuals who get in trouble with the law; certain assistance and learning with appropriate social behavior, like many retarded people are followers and so get in trouble with the law because of that.

Others have some medical problems, although the adults who are mentally retarded today probably

don't need as much medical specialization as maybe some of the kids because, unfortunately, the services in the past for the mentally-retarded, if they are adults by now, they may not have made it through to adulthood with massive medical problems.

With vocational training a whole continuum needs to be developed all the way from prevocational, from adolescence, both work training and skill training, where you learn the same expectation is on you for coming to work on time, for the type of
[6-12] relationship you have with co-workers, and also the skill training for various type of employment.

Mentally-retarded persons can take a whole range and be capable of a whole range of performance and not just some of the menial tasks that some programs offer them right now.

The training should also be in an environment as normal as possible instead of having always segregated places where the only people working around you are also mentally-retarded and also having substantial trouble. Still, the training should be provided in normal settings also.

Industry has been very good. I have run seven or eight work stations on the floor of industry, where the actual training, even for severely-handicapped persons can be right on the floor of industry, where people have also the dignity of going to a factory to work and not a sheltered workshop for mentally-retarded or an institution, which is sometimes demeaning if it is labeled like that.

So they can provide the actual skill training and that is conducive also to the dignity of the person.

The other social activities, training provided in transportation, shopping, choices allowed in the churches they go to, and then the people moving along the continuum from more structure to less structure all the time. That doesn't mean that everybody will end up independent.

[6-13] Many people, especially after long years of institutionalization, may never become totally independent, but they certainly can reach a point where they need only minimum supervision and they can exercise any freedom that they can and take advantage of as many of the types of opportunities that are afforded all of us that they possibly can.

* * *

Q. You mentioned that you had some direct experience in running a community-based mentally-retarded agency.

What agency was that?

A. The Eastern Nebraska Community Office of Retardation.

Q. And where is it located?

A. The major central office is in Omaha, but it was a five county, very large community-based program that served Eastern Nebraska.

Q. And do you have responsibilities for community-based services in your current position?

A. In my current position, yes, all the services, both institutional and community, in the State of Massachusetts, yes.

* * *

BY MR. PEABODY:

Q. During what period were you the director of ENCOR?

A. I helped start the agency back in '69, but I was not the director then. I was the director of research and planning, which meant I helped develop all the programs, write them up, get the funding for them,

[6-18] get them going, and then go on to further development.

I became director in very early '72 or '74, excuse me.

Q. And that lasted until what time?

A. Until March of '76.

Q. Could you describe briefly for us the general philosophy of the agency?
A. The agency was totally based on the principle of normalization which I discussed yesterday, which meant that all aspects of the program were designed to not only allow the person to move along the same development continuum as everyone else, but the old programs were designed to be the same as you would find for anyone else, with a special input that we needed for the mentally-retarded children.

We would be moving people along the continuum so they could use as many of the same services as anybody else did. In other words, we wouldn't, unless we had to, have special recreation programs, but rather in doing that we would work with the YMCA, we worked with all the other agencies, the Boy Scouts, the Girl Scouts, that serve anybody and are supposed to be available to anybody in the community and get them to accept mentally-retarded persons.

It was quite a large agency. We were in about 103 different locations with individualized residential types.

[6-19] We had eighteen — nineteen group residences that now house six or eight people. We had more than sixty different types of residential that would have three or less people in it. It might be a foster-home model or a staff member living with adults.

We had a continuum of vocational training. For children we had all the pre-school children from zero to five in the ENCOR agency in Nebraska at that time and provided in-home training for parents and staff to go in and work with the parents and out-of-home training for infants.

The integrated pre-schools I talked about were created at nineteen centers with maybe four or five kids in each center who would be with groups of thirty or thirty-five non-handicapped kids, with our staff in there too.

In adolescent education programs when the schools would still exclude most behavior problems, the most medically-involved children, we would provide the service and even that we got integrated. The public schools wouldn't accept it, so we contracted with the parochial schools to use space in their buildings so they would be near other high-school-age kids.

Vocational training centers — we had five large ones, but we are moving more to work stations on the floor of industry and we had seven or eight of those in-job placements and on-the-job training
[6-20] opportunities; and a network of support services that would insure there was case management, coordinating entities, and make sure there was a continuity of service.

The recreation specialist that would work with the generic recreation people; schools that would give behavioral intervention input to the houseparents.

BY THE COURT:

Q. Are you talking about Omaha?

A. Right, and the five counties surrounding Omaha.

Q. Let me interrupt to ask you a question.

In that area in Nebraska did you have or do you have an institution that could be compared to Pennhurst? I am talking about size.

A. Yes. We had one large institution, the Beatrice State Home in Nebraska. At the time I left it was about 1100 people. It was at one time, I forget, about 1600, 1700 — no, 2300, I think, back in '69.

One of our objectives in Nebraska was — and we were very lucky, we had a governor that allowed us to do a large study of the State institutions and the needs in the community that were not being met.

Beatrice in '69, was typical of most institutions: it was large, it was overcrowded, it was profes-

sionally understaffed, it was professionally isolated, out in a rural area, and could not get the professional staff.

[6-21] So the governor allowed us to do a large study and say in what direction we should go in Nebraska — should we build three more large institutions, one in Western Nebraska, one in Omaha, and one in Central Nebraska, which was a proposal at that time? Or should we go a different direction.

So the study contained both what needed to be done to clean up the Beatrice State Home and in which direction should the State go; and we opted for the model normalization.

Really, it had not been applied on a systematic State basis and we were thought somewhat radical at that time, but it has been adopted across the country now.

We decided we wanted six regional offices, not six centers, residential units, but six regional offices and each of those regional offices would be responsible for the development of a continuum of community-based services so that no person within that region would have to leave the physical boundaries of that region for any type of service; and that one of our goals would be to eliminate the Beatrice State Home.

We set out with very reasonable time lines, reasonable goals, reasonable legislative packages that had to be passed to allow us to do that.

We did start that in '69 and we were very successful. We got the institution down from the 2300, until in '76, when I left, it was about a thousand — 1100.

[6-22] Q. You are talking about a thousand or eleven hundred residents who were retarded?

A. Who were still at the Beatrice State Home.

Q. Retarded?

A. Right.

Our agency — for example, we are the largest agency. The population base for my five counties was over a third of the State's population and fifty percent of the children had known poverty in urban areas as well as a lot of rural areas, so we had a mix of service delivery types of ways we had to look at it.

Q. Let me interrupt and ask you again.

In Nebraska you just talked about this one at Beatrice, did you call it?

A. Yes. We only have one large State facility.

Q. This is the only one in Nebraska?

A. Yes.

Q. What is the population of Nebraska or what was it approximately?

A. 1.6 million, I believe.

For example, our agency had, in '69, exactly 769 people. When I left last year we only had 286 people at the Beatrice State Home.

Q. When you say you only had 200 and some, you mean 200 and some from that five-county area?

[6-23] A. From that five-county area, right; and every regional office took that responsibility of getting the people from the region back into their region.

THE COURT: I see.

All right. You may continue.

BY MR. PEABODY:

Q. Was ENCOR accredited by any national accreditation organization?

A. Yes. The Joint Commission of Accreditation of Hospitals, for facilities for mentally-retarded.

Q. Are you able to provide all of the services in your agency in normalized settings?

A. Yes, except one. I mean we went through some learning experiences too.

When we first started taking out really severely profoundly-retarded, multiply-handicapped, medically-complex kids and adolescents, we were a little

shaky on that. I mean we were a little scared, you know, and wanted to be as protective as we could, so we started it in a wing of Douglas County Hospital, and we found out that quickly, after a couple of years, services for medically-handicapped or medically-involved children, multiply-handicapped could be had, did not need to be in a hospital setting.

We just stabilized the medical problems very rapidly or found even a foster home where the
[6-24] mother might be a nurse but doesn't want to work out of the home, you know, would rather work at home and earn money doing that, so we would be able to take even a medically-involved child.

So that one service, I'd say, of the 130 locations we were in, was not normal; it was a hospital setting.

* * *

[6-25] Q. Did the mentally retarded persons in your program move through the continuum of services which you have described?

A. Yes. In fact, they moved through a lot faster than we expected. In cases where we thought some adults would need two years in a group residence before they could move to semi-independent apartments, they usually surprised us and were ready to leave and successfully left after a year or less.

So there was quite a bit of movement through the program.

Q. Were all levels of mental retardation spread through these programs you have been describing?

A. Yes. In fact, most of them were severely-handicapped because the more mildly-handicapped or high moderately-handicapped we could move successfully with minimum amounts of support into
[6-26] regular programs, whether it be public school, vocational-training programs, they were provided; and

adult education and those kinds of services for the remaining severely-handicapped population.

Q. So in your services you were able to serve severely-handicapped, profoundly-handicapped, and medically-involved persons also?

A. And for extreme behavior problems too, yes, and people in trouble with the law.

The courts, just as an alternative, had a special program for retarded adults, adjudicated and non-adjudicated, who got in trouble with the law.

Q. Could you give us an example of how these multiply-handicapped persons were served?

A. By individual cases or by the description?

Q. Let's take a pre-delinquent person that you described.

A. For a person that was in trouble with the court, in fact, the only people that we ever, in our seven or eight years of experience, had to send back to the State home was somebody that got in trouble with the court; and the court did not at that time trust us — or not trust, but they didn't know that we would provide a secure environment so they felt it necessary to send him to the State home.

Because of that, we designed a special program and got the courts approval that he, the person, whoever, could use that as an alternative placement that was secure.

[6-27] What we did was develop the same types of residential environment, two or three persons in groups, in maybe a small house with a couple of staff members, but we made it secure by the staff members.

We didn't necessarily have to lock the doors. In fact, we didn't lock the doors and we could provide a continuous supervision through the staff.

Now we have found through some of our other programs that you don't want to group people with

similar problems together. You don't want to put people with severe behavior problems in a group together and when a kid loses his head and goes into biting, you know, that kind of phenomenon goes on, and from that learning experience we found that we should not also put people in trouble with the law together. They would sort of feed on each other with the types of problems and the types of interests that they had that might not be socially-acceptable, so we broke them down into small groups of just one or two in a regular service system with staff providing the security and the support and the training for the people, and they could attend like one of our work stations on the floor of industry.

Typically, the people that get in trouble with the law that are retarded are the more mildly-handicapped, not the more severely-handicapped physically, and they have severe emotional problems too.

The mildly-retarded know they are retarded,
[6-28] know they are lower in value and really end up with a lot of emotional problems along with that, so we put them in situations that were not demeaning to them.

Instead of having them go to vocational training with other mentally-retarded persons we would have them go to a supervised work station, assembly-line operations.

We had a wooden-shoe factory in Wauneta, Nebraska, and we did maid-training for Holiday Inn, you know, those types that are more dignified.

Then after a while, with the court's approval, we could move them into a regular residential program, typically a staff apartment that did not have to be secured most of the time.

BY THE COURT:

Q. That training for the Holiday Inn, was that just in connection with the Holiday Inns out in Ne-

braska or are you talking about nationwide?
A. No. What we did, so we would have more life experience in training, we would contact just the Holiday Inn, and we would contact the people and train people to maintain both the Holiday Inn and other local motels.

We could train as many people as we wanted at the Holiday Inn.
Q. Have you had any other experience with or do you know of the programs in Pennsylvania in connection with the Howard Johnsons that are built in
[6-29] the State parks here for the primary purpose of training?
A. No, I am not.
Q. Very well.

That's the reason I interrupted when you said Holiday Inn. There is a similar project in Pennsylvania in connection with Howard Johnson.
A. It does work very well because even the people that we had in workshops, in our vocational-training centers for several years, who sort of had plateaued, they really weren't increasing a lot in development; but once they moved on a continuum and were in a real work situation, they just soared in their capability, and especially with the dignity of being able to have a regular work environment and be with other people.

THE COURT: All right.

BY MR. PEABODY:
Q. Could you give us an example of how the daily routine of a person who was severely or profoundly-handicapped with medical problems went wrong?
A. Okay. People with, let's say children with severe medical problems continually — well, the medical problems usually were not so constant that the person could not participate in a developmental program.

If they were the type of medical problem, for example, constant upper respiratory problems,
[6-30] uncontrolled seizures, it might be that they only participate — well, they might live in this hospital unit I was talking about and only leave there for a program during the day of a period of four or five hours with a nurse being at the program area in case there were a problem.

Or it might be a problem — well, it would be a problem medically that they could start attending both a full-day program outside the unit and eventually, if possible, move to a foster-home setting or back into their own home.

Their activities recreationwise would probably be more limited than those of a non-medically-involved person, but they would get outside and participate in other activities, as long as it was not endangering the medical problem.

Those kids are very few. In fact, we found that we could stabilize medical problems very rapidly and you can get seizures under control very rapidly.

You can resolve the problems, for example, of people laying down all the time. That's why they have constant upper respiratory problems. If you are laying on your back all the time you get what is known as a pancake chest, a gradual pushing down on the chest because you are not in the right position; and that decreases your lung capacity and then you end up with constant upper-respiratory problems.

If you get a person upright into a position in a chair, where a person can navigate around and get
[6-31] the circulation going better, then you don't end up with those problems.

We have found causes in the past that certainly are correctable. We found in an area, even our area had about 550,000 people in it, that we probably

only needed four or five beds in that medical unit or a medical unit like Children's Hospital. We moved people through very rapidly and again there major management model does not have to be medical. You can just be sure the medical backup is there when needed.

Q. Was there any class of retarded persons that you were unable to serve?

A. No.

* * *

[6-32] Q. Did you have any trouble at all with the parents of children that were in the institutions returning their children to the community?

A. Yes, we did, and that was —

Q. How did you handle that?

A. In two ways.

That's understandable, when parents had no alternative they had made a decision to sever themselves from the child, and it is very hard to go through that process again. I mean I can understand the emotional problem in doing that.

[6-33] A lot of it had to be demonstration. A lot of it had to be, you know, waiting with those parents until they saw that the community programs were viable. They saw that the individuals just like their sons who came out did very well when they had a chance to see them, so part of it was a waiting game, instilling those parents.

Another part was the advocacy organization in Omaha, the Greater Omaha Association for Retarded Citizens, which had a special program and the program was called Pilot Parents.

What they did was twofold:

One, when a child was identified as their sort of child, when the parents had an experience where their son or daughter was put out of the pen, so

there was less fear about having a child belong to the family.

Second, they would participate when a family would really resist their son and daughter coming out, and especially we thought it was best for the children and we talked with the parents to try to convince them of the fact of at least giving it a try.

Q. I will put this in the form of a question:

Have you experienced a situation where a particular retarded child would move from the parents' home into, we will say, a foster home in that same community?

[6-34] A. There is a problem of parents accepting the fact that another family can do a better job with their child than they can that we get into, and it is a problem.

The way that we address that is that we didn't have a normal type foster-home program that consisted of just another family taking your child; they are professionals that we train extensively. The home provided just as much structure as maybe a group residence would provide, just as much supervision, just as much training in the home.

So the image of that being just a family and just a foster home is taken out of the situation. People saw it was another professional group and they didn't have the same feelings that they would have had.

[6-35] * * *

BY MR. PEABODY:

Q. Is it your opinion that all mentally-retarded persons can be integrated into these community settings you have described without significant problems?

A. Oh, certainly, yes.

* * *

[6-36]BY MR. PEABODY:

Q. While you were with ENCOR did your agency serve every type of person who formerly lived in an institutional setting?

A. Yes. As I mentioned, we got our population from five counties down from well over 700 to a little over 200.

Q. Did you evaluate particularly or otherwise whether these mentally-retarded persons who were formerly residents in institutional settings developed and were habilitated one way or another through the use of your services?

A. Yes. In fact, we did a formal statistical analysis
[6-37] taking a two-year time period for all the children and adults who left between '74 and '76; and when you talk about the change in the persons and in the group, you really have to look at two dimensions.

One is the movement of those individuals. Were they able to move from a more structured situation after they came out of the institution to a lesser and lesser- structured; so you would have indices of movement as a criterion.

Second was clinical development. People that came out did not walk or were not ambulatory, what stage of development did they reach and how rapidly ambulation was existent, complete mobility, mobility with adaptive appliances.

There were other clinical indices, such as speech. People that came out with no speech that were able, you know, in one year, to be speaking fourth-grade sentences and have a vocabulary of 175, and their indices of social development and even academic development.

So you have both movement and clinical indices.

Q. Could you just discuss with us generally what the studies indicate in terms of growth and development?

A. The study indicated quite a rapid progress of individuals after they left the institutional services, both on the movement and the clinical indices.

For example, for about 135 adults that left the institution, that had to be placed in the highly-structured residential situation, there was only a twenty-
[6-38] four month turnover time before an average length of time in a heavily residential structured program in a community program and that is only two years before they can move to a higher, semi-independent living setting.

On the clinical indices, that really varied with the type of index.

For example, of the seventy-seven children in that two-year period that we brought out of Beatrice State Home, I believe all but — I believe that fourteen came out with not even the ability to suck, must less chew or swallow, so they were still on liquid diets and we had to go through the process of teaching them to suck and then swallow.

You have to do that. There are so many psychic problems of feeding handicapped people. For example, if they are not taught to chew and they are kept on pureed foods, you end up with problems that cause constant constipation. Constant constipation causes seizures.

If you get rid of the constipation you have to use enemas and people get dependent on enemas and there's all kinds of dental problems, so there's all kinds of problems if you don't bring the person along if you can.

Of these fourteen children that could not even suck, after the two years I think five of them were eating independently and eating regular food independently. All but one were past the chewing stage,
[6-39] maybe eating with assistance or still being fed, but certainly past the chewing stage and on to hard food.

Other indices of language. The biggest scores in language were kids in a setting where other people talked and they just started growing in language.

Ambulation was the other big one, where almost all of the kids who had come out that were not ambulatory were ambulatory or ambulatory with assistance. They may have a position chair, which is a specially-built wheelchair, just for them so that they can navigate in their own environment.

I don't have the exact data here but the growth was tremendous.

Q. Can you give us some examples, a couple of examples of individuals who showed the kinds of changes that you have been describing?

A. Okay.

Take a young child — now, thank goodness, we didn't have a lot of young children still at Beatrice State Home because we had stopped admissions from our five-county area as of '69 and we were handling them in the community instead of having them go there.

But one child that had been admitted — I will use first names if that's all right — Jenny came out.

We went to the institution and found her down there, which she did not know she entered at age three. She had massive problems. She had
[6-40] hydrocephalus, pressure on the brain. She had spina bifida because she had nerves that were pinched through an opening in the cervical cord. She had massive urinary-tract and kidney infections.

In fact, when we went down there she was dying. What was happening was that she was diagnosed as profoundly-retarded. The institution sort of laughed at us when we said we wanted to take her out to the community.

We got her out, went through a serious of operations. We had to reshunt the hydrocephalus. They had shunted her once and it got infected once and they took it out and it did not relieve the pressure on the brain.

She went through an operation to close the gaps in the spinal cord because of the spins bifida. Because of that she was paralyzed from the waist down, but that doesn't mean that she can't become mobile.

We went through a series of minor operations to resolve the infection problem in the kidney and urinary tract. That took six, seven, or eight months before she could participate in a full day's developmental program.

At first they started right at the unit, the hospital unit that she was at. Then she enrolled, we got her a positioning chair, we got her a specially-fitted chair that she could navigate and she ran all over the unit after a while.

That had a tray, you know, in front of her, so that a lot of activity could go on with her using the upper portion of her body.

[6-41] Then she was able to enroll in the Creative Learning Center, which was one of the preschools that we used with our staff in there and she was able to participate with normal kids in the preschool program.

In six months of that program she was speaking fluently, even was beginning to walk in an A-frame, even though she was paralyzed and she was really interacting with the other kids.

Then she was able to move. She got up to normal speaking level very rapidly of a normal three-year-old, after six months in the program.

Then they began to wonder whether she was retarded at all. If she was, she was only mildly retarded.

Then, with all of the medical problems resolved other than the management problems of paralysis, which a medical person had to train somebody else to do, one of the teachers at the school, they were moved into alternative living — a foster-home type, living with another family.

When I left her own family was talking about taking her back at that point, so Jenny would probably represent quite a few children that came out with medical problems.

Mike might be another good one because he is one of the first adolescents we brought out, to give
[6-42] you an example of adolescent developmental problems.

When he came out he was not fully trained yet. He had a brace on his left leg and he had some motor problems in his left arm, so he is semi-ambulatory, not quite; no speech, and he had been labeled autistic.

You never really know what that means, autism. It can mean an overlay of emotional problems or it could mean that it is a diagnosis which is very unclear, but he didn't relate to people at all.

He came out to our first children's community residence, which housed six kids.

He also had another problem of deformity of the head that was not hydrocephalus, but some sort of a condition that only deformed part of his head, but you could take care of that with his hair style that made him look like other kids so he didn't stand out because of his hair style.

He lived in that group residence and had to stay in our developmental center, in which at that time we had quite a few segregated centers. They were centers just for retarded kids until we moved to more public-school programming in the integrated centers.

He had to stay about two years, but he rapidly gained speech. After two years he was accepted into the public schools trainable program and at that time the public schools really didn't have a remedial
[6-43] training program. They didn't really want any kids that they had any major problems with and then, only after a year in the training program, they were considering him for an educable program — reading, writing, arithmetic — so he was probably only mildly retarded even though the institution had said he was severely-retarded or lower-functional when he came out.

He was another one that they said probably would not function in the community.

I could give you many other examples of adults.

Q. Is there an example of an older person you could give us?

A. Quite a few, yes. I could pick almost any.

Well, I heard Downe syndrome mentioned in earlier testimony and there are such myths about Downe syndrome people that maybe I ought to take a Downe sydrome adult that came out.

They had institutionalized him for about twenty years and coming out into an adult group that had just eight people, in two years he was ready to move from the adult residence, which was more of a highly-structured program, to an apartment where a staff member just lived next door, that checked in on him every now and then, at least once a day.

He had joined a regular bowling league and was doing well. It was one of his favorite sports.

[6-44] He navigated the community totally. He worked at the Benson Vocational Centers, one of our vocational centers, for about a year and a half and that was while he was in the group residence.

He moved to a work-industry, I think Geiger Food Products. He was still independently living,

but still needed structure in the work setting, so he was working at Geiger for quite a while. I don't know if he has left yet, but he was quite successful.

There are many adults like that — different kinds of training periods, they need. Some may stay in the structured vocational or residential setting, but they certainly move along, needing less and less assistance on an ongoing basis, and really lead full lives.

It is amazing to watch some people come out of institutions. Some people come out and they live in an apartment and they go to their apartment and you find that they haven't decorated it and you sort of wonder why, why haven't they pictures up or other belongings.

And you try to encourage them. They don't know how to express themselves. They have been in such large congregate groups for so long they have no self-identity and self-expression.

Once they get that in one area, like we encourage people to decorate their own space or living
[6-45] space, they start getting it in all other areas.

Some people might think that people talking back to you is not good, but it is certainly self-expression. They start really making their own choices and making their own demands, as well as knowing how to make those choices in the community and to watch their developmental process.

Often a person really does not know how to be an individual because he has never been treated as an individual. It is quite amazing and it is quite rapid.

Q. Was there any mentally-retarded person in your services who did not grow or develop in any way?

A. I can think of one man. I am not sure I can say no growth, but his growth was cyclic.

We were a data-based organization and really looked daily at the developments and kept measur-

ing the data base for a unit data decision and his growth was cyclic.

You know, he would grow, build up to a level, and he had some problems and then he'd go down. It was sort of a cyclic type of growth that he had that was not too much going up for the whole period.

But that was only one young man and we had resolved some of his problems by the time that I left. We had found out that he was deaf and he had some emotional problems and he had some medical problems.

That's probably the only one I can think of.

[6-46] Q. By participation in the available services did the level of functioning of all of those participating go up or go down?

A. Oh, it went up dramatically. In fact, I'd have to say that with the services we have been able to teach the young, to provide a continuum of movement for them, a program for them. You could see the scale of mentally-retarded pushed up.

All of a sudden we never even end up with people being profoundly-retarded any more. We have sort of eliminated that in the sense that people who are profoundly-retarded are those with no communication skills and laying on their backs.

The people that came out with a diagnosis of severely-retarded were monitored retarded and the scale was pushed up for all the persons.

Q. Did you ever come in contact with a previously-institutionalized person who seemed to want or desire to return to the institution?

A. Two — the two phenomena seem to exist — the answer is yes.

Some adults did not want to leave the institution. Some adults, when they got into the community, initially wanted to go back to the institution.

I am sure this phenomenon, from what I have seen in the other states, does exist.

In the first case you have a situation where probably the external fear that a person receives
[6-47] about community living is through watching Dragnet and Gunsmoke and they are a little leery about going out into the community when what they see on TV is, you know, uncomfortable to them about walking out there.

So they have some inhibitions about the challenge and what I have specifically done is ask them — not force them, but asked them if they are willing to give it a three-month trial and come back in that time.

I think I have had only one man, mentally-retarded, seriously emotionally-disturbed, that after that trial period still wanted to go back.

The other instance is that the community does offer the service system or life that a person needs in the community is quite a bit more demanding than some institutions place on those persons and some adults reach the point of, well, I'd rather lead the lazy life in the institution where there are no demands on me, where nobody does anything relative to making me work.

Some will hit that point and then they have to make a choice. There is the dignity of being out and having freedom and the dignity of being able to earn your own living, and the question is whether it is worth that tradeoff; and most decide that it definitely is.

I have never had anybody want to go back for reasons of the challenge that it places on them, and
[6-48] the demands; but sometimes there is an initial culture shock that they go through and that has to be worked through.

Q. In your opinion can community-based services overcome this apprehension or lack of preparedness for persons who come into the community to live?

A. Yes.

Q. And was ENCOR able to overcome these kinds of apprehension?
A. Yes.
Q. Are you familiar with the community-based mental-retardation services in the Commonwealth of Pennslyvania?
A. Yes. I have done quite a bit of work with Pennsylvania since about '71 or '72, both having some people that work with me work here, so I keep pretty close contacts.

Also, I did some of the early training programs for Pennsylvania in the evaluation tool that they use for the community residential program.

So I have, I think, since '72 done three large workshops in '72 and '73. That included evaluating a lot of the programs, especially around Harrisburg, around Pittsburgh, and around Philadelphia.

And then I participated here in evaluating other programs.
Q. Have you had an opportunity recently to visit certain community-based mental-retardation programs in the five-county area surrounding Philadelphia?
[6-49] A. Yes, I have.
Q. And when did you visit?
A. March 12th and March 13th.
Q. 1977?
A. Yes.
Q. And where did you visit?
A. I visited the Montgomery County Mental Retardation Center and spent quite a bit of time with the staff of that center.

I visited the women's group residence on Mount Airy Street in town.

I visited a women's residence in Pottstown for eight women.

I visited an adolescent residence for boys, six adolescent boys, two of whom were from Pennhurst.

I visited St. Christopher's Hospital in the respite-care program that they have available for families on weekends.

I visited Horizon House at 1315 Federal Street, which was a women's residence, with several from Pennhurst.

In fact, in every program there were several that had originally lived in Pennhurst.

I visited the Intercommunity Action Program and I visited two sets of apartments they had for mentally-retarded adults, several of which were originally from Pennhurst.

[6-50] The Elwyn Institute, which runs a large apartment-training program that serves twenty-three people, some from Pennhurst.

And the Eman coeducational residence on Vernon Street that had both men and women, some from Pennhurst.

* * *

BY MR. PEABODY:

Q. Did you visit nine or ten different programs in the two-day period?

A. In this trip, yes.

Q. And how was your evaluation conducted?

A. Mainly just by staff visits, by interviews with the staff, by interviews with the residents, by a review of many of their past evaluations that had been done on the places, by discussions with other people that were familiar with the programs, and any materials that they had available that I could evaluate.

Q. What is your opinion on the level of the quality of services available?

A. I think they are excellent. I think they are very good.

[6-51] In fact, Pennsylvania has had several years, or more than that, five or six years, developing community service and it is very good and they monitor quality of that very extensively based on the same principles that we have been talking about, based on normalization.

The people in these residential programs were certainly leading a full life. They were involved in all kinds of community activities. They had access to adult basic education when they wanted it. They would decide for themselves to go at length about the type of activities, the jobs they had, the way they really interfaced with the community.

The State spent a lot of time and we talked a lot about the changes in people they had seen, especially those that came from various institutions, not just Pennhurst.

Q. Were all of these programs that you visited offering an adequate level of habilitative care and treatment?

A. Yes, definitely.

Q. In your opinion were adequate and perfectly-qualified staff available in the various programs that you visited?

A. Yes.

Q. Were the programs you visited all offered in normalized settings that you have described?

A. Yes.

MR. PEABODY: Your Honor, may I approach the witness?

[6-52] THE COURT: Yes, you may.

BY MR. PEABODY:

Q. I now direct your attention to Photograph 70 on page thirty-eight of U. S. Government Exhibit 48, and ask you if that is an accurate representation of

an external view of the apartments you visited on Parker Avenue.

A. Yes, it is.

Q. I now refer you to Photo 74 on the next page and ask you if it is an accurate representation of the exterior of the adolescent residence you visited on that unpronounceable avenue?

A. Yes, it is.

Q. I next refer you to Photograph 76, again on the next page —

THE COURT: I just want you to know that anyone that can pronounce the name of the river that flows nearby, not the Delaware, can also pronounce Wissahickon.

BY MR. PEABODY:

Q. I next refer you to Photograph Number 76 on page thirty-nine, and ask you if it is an accurate representation of the external view of the group home at 143 East Mount Airy Avenue.

A. Yes, it is.

Q. Photo 77 on the next page, is that a view of the surrounding area of that group home?

A. Yes, it is.

Q. Is this representative of the kinds of settings you found throughout your tour?

[6-53] A. The only one that was slightly different was the Elwyn Institute apartments. It was in a quite a bit more urban area, a large apartment building, where they had one floor of apartments that they did training in.

Otherwise, all of the community residential programs were in very similar neighborhoods. They were in residential areas.

BY THE COURT:

Q. Do you recall where that apartment is located, the Elwyn Institute apartments that you have just referred to?

A. Do you have the address? I probably have it.
Q. I just wondered if that was located out at the Elwyn School or in that vicinity.
A. No.

MR. GILHOOL: On Chestnut Street in West Philadelphia.

THE COURT: In Philadelphia?
Is it connected with the Elwyn School?
MR. FERLEGER: Yes, it is, your Honor.
Their apartments are at 3900 Chestnut Street.
THE COURT: Very well.
I just wanted that clarified.

BY MR. PEABODY:

Q. Is the parents' consent important in the programs?
A. Yes, it is, in every instance.

[6-54] I think yesterday I covered a lot of them, the fact that they learn how to navigate in the community and be in the community, learn how to utilize shops and recreation facilities and churches and transportation lines, to be near them, so certainly the location is important.

The ability to interact with neighbors, so that you are not in another kind of setting that you only associated with handicapped people is important.

The image of the program is also important. We have done a lot in the past harming those people by stigmatizing them. If one of these good residences has a big sign out front that said "Community Residence for Retarded People", I am sure the neighbors, like has been shown, would be much less willing to accept them as members of that community or not be slightly fearful of them, just treating them differently, again the expectation problem.

But the dehumanization of living in places where they are stigmatized or unwanted in that community or stand out, like you wouldn't want a

big fence around one of these either, the people would think this was potentially dangerous if you had to have a great big fence.

Normally, the appearance in the community is highly important.

Q. Normalizing?

A. Yes.

[6-55] Q. I now refer you to Photograph 69 on page thirty-six and ask you if it is an accurate representation of a living area or a living room in the women's residence at 500 North Franklin Street in Pottstown.

A. Yes, it is.

Q. Is Photograph 71 on the next page another living area? Is that an accurate representation of the living room in the apartment at 300 Parker Avenue?

A. Yes, it is.

Q. And Photograph Number 73 on the next page, I ask is that an accurate representation of another living area, this time in the adolescent residence on Wissahickon Avenue?

A. Yes, it is.

Q. And were these kinds of living rooms typical of those in the group residences you visited?

A. Yes. They were all quite a big beautified and very comfortable, home-like environment.

Q. Can you explain briefly why these normalized settings are important?

A. For a range of reasons, mainly — well, we discussed comfort and beauty yesterday, but really the training of selection, of choice, of self-expression.

Most, in fact all of the adult residents that we visited, you know, told us the stories of how they got decorated by the residents' participation in decorat-

[6-56] ing the living rooms, the residents being able to make choices about furniture and decor, as well as experiences of buying and shopping for those, the training experiences of keeping up your own home, so they are able to move to an apartment.

All adults participated in the actual maintenance of the house. They would rotate on both the cooking and the cleaning, so it is, you know, a real-life experience. They are involved in a real live house, not an artificial type of environment.

Q. I now refer you to Photograph 79 on page forty-one and ask you if it is an accurate representation of a bedroom in the Interac Shoreham Apartments that you visited.

A. Yes, it is.

Q. Is Photo 83 an accurate representation of the bedroom at the residence at 729 Vernon Road?

A. Yes, it is.

Q. Photo 78, is that an accurate representation of the bathroom in the Interac Shoreham Apartments?

A. Yes.

Q. Is Photograph 82 an accurate representation of a bathroom at the Vernon Road residence?

A. Yes, it is.

Q. Are these normalized settings, in your opinion?

A. Yes, they are.

Q. Is privacy possible in these settings?

[6-57] A. Very definitely.

Q. Can you describe for us how they are important in other ways?

A. Well, I started to say, you know, it was very —

Well, all the residents were so proud of their rooms and the fact that they had their own either private or at most semi-private rooms.

I think one of the proudest things that people have is their own living space, the ability to be alone if they want to, the ability to have their own possessions and not have to worry about whether or not it is going to be taken away or stolen, to have a place to keep those possessions.

The young man in Picture 83 was showing me his own TV that he had bought from income that he had from a workshop. He had places to store his

own possessions. He can start to really learn about taking care of his own things.

Involved in that whole process is teaching and training about budgeting your money, about shopping in the community, about sharing your own possessions — things that we would normally learn or normally have learned that have to be taught now.

This young man had been institutionalized for quite a while, but the pride comes through and the pride comes through very strongly.

Q. Are these representative of the bathrooms and
[6-58] bedrooms that you visited in the other various residences?

A. Yes.

Q. Again, are these normalized settings in your opinion?

A. Yes, they are definitely.

Q. Do these settings allow for freedom of movement in normal daily living?

A. Yes, they do.

And the residents talked extensively about what they did and what the whole rhythm of the day and year was like.

In fact, quite a few of the residents had taken vacations last summer to various places. California was one, Florida was another, and they would talk about these and show the possessions that they had gained while they were there.

Typical, normal life style, I guess.

Q. You talked to the residents in the various group homes?

A. Yes, I did.

Q. Did you talk to houseparents and other professional people there?

A. Yes.

Q. And were you able to ascertain whether any of these retarded persons, formerly residents at

Pennhurst, had changed, grown habilitative through the various programs available?

A. Yes. Two of the things that I was very interested in when I was talking to each of the staff of these programs was, one, the movement. You know, how
[6-59] people actually moved from that type structure to a lesser-structured situation, and much movement has occurred from those types of group residences to apartments, like the one on Parker Avenue, and more people were ready to move.

They were developing new apartments to move to.

Then the staff and the clients would talk extensively about what skills the person had gained that allowed them to be able to move from that setting to another setting of less structure.

There were many discussions about the lack of skills persons left the institutions with and how rapidly they gained the skills, whether they be in the area of cooking or sewing or clinical things like speech, different types of social adaption skills, the ability to navigate in the community.

The adolescent residence was very interesting and drew a very, very sharp contrast between the four boys that had previously lived in their own home and then came to the adolescent residence, and the two boys who had been at Pennhurst for several years and came to the community residence.

They indicated that it was a very sharp contrast with the types of problems and behaviors that the two boys from Pennhurst had, that took a long — well, it took about a year of stabilizing those behaviors to get rid of them and now they were, you know, they were fine.

They also were pretty heavily medicated when
[6-60] they came out of Pennhurst and they got them off that medication very quickly. There was quite a bit of contrast particularly in the rapid growth.

Q. Did the services that you visited represent a continuum of needed services to meet the individuals' needs?
A. They represent a continuum, yes. I think the programs that we are looking at now are even developing more steps in the continuum that they had not developed before.

They certainly were all willing to expand services to accommodate many, many more persons from Pennhurst or elsewhere. They are taking a look at staffing patterns that are going to have to be different as they serve more and more severely-handicapped persons, to prove that the same continuum will work for the more severely-handicapped.
Q. In your opinion can the services and programs you visited be expanded and still maintain the high quality which is current?
A. Yes. I talked to each of the program directors about how much, since they are non-profit agencies, how much the agencies are really looking at expansion, how much they are willing to expand, what they think it would take to assist them if they perceive any problems in expanding.

And they were certainly all willing, they were very interested people, very community-oriented in their own communities, and want to make sure that their growth is appropriate to those communities.

[6-61] But they only see a few problems and are rapidly expanding their services to meet the needs of those problems and those problems will be resolved relatively easily.

That was my conclusion from my evaluations also.
Q. In your opinion are the programs monitored closely enough to insure good-quality services?
A. Yes. In fact, the model that provides the community-living arrangements is very good for monitor-

ing. What I mean is that what it does it set up almost every community program. That community program may have five or six residences plus a day program. They may have one program.

But each of those programs has its own board of directors and typically the board of directors includes not only some professionals but parents; it includes interested citizens, so you have got a board over programs in the community that are constantly monitoring the quality of that service.

You have got a situation where — you have seen the pictures — the house the community residence is in is abutted by two other houses and the houses across the street. You really — I mean the problems that have come in large congregate settings cannot come up here. You are monitored by your neighbors, by the schoolteacher when the kid goes to school, who see if the kid is having any problem. You have got so many people monitoring the
[6-62] community programs that it is much better than any other type of setup.

In addition, Pennsylvania for several years in these programs has been utilizing an evaluation system that is based on normalization. It is based on quality of service and the rights of the individuals being adhered to and each program's community residence is not only evaluated on that instrument annually, I believe, but also the application packet for new programs is centered on the same quality considerations.

So that they know in the development process that the service is going to adhere to their quality program.

Q. You mentioned problems during your tour.

Did you determine whether there were any weaknesses in the system?

A. I think there are a few, but it certainly does not deal with the individual services.

It deals more with — they need to develop more community services. They need to have higher visibility to the mental-retardation concept at the base service unit level.

There needs to be more research and resources at the base service level, which provides the case coordination and the case management and coordination.

There seems to be available activity levels from various service units. Some were highly involved, others did not have enough staff to allow the services to expand a lot; so I think the independence
[6-63] and visibility and accountability of the base service units could be improved and more resources supplied.

Secondly, the support services, the availability of vocational-training services, the funding of vocational training — there seemed to be a slight problem that they totally relied on the funding programs for adults that came out of institutions.

These, however, are easily resolved. These are not major problems.

I think that as we increase community programs, that is residential, we are going to have to take a look at increasing the range and availability of vocational-training programs.

Q. What are your general impressions and recommendations as a result of your tour of the various community-based mental-retardation programs?

A. I think the two recommendations I just talked about.

The major one would be obviously to increase the number of community programs, to insure that there is a rational growth to those programs that allows for the stabilization and consistency of quality that we see now.

Second, that they take a hard look at the lines of accountability and the available resources for case

management so that we insure an ongoing monitoring and coordinating system, and the expansion of
[6-64] some of the support services like vocational training to insure that there are enough out there.

* * *

[6-95] **Testimony of Dean B. Settle**

* * *

[BY MR. RIVERA:]

Q. Do you know whether any of the mentally-retarded citizens can be gainfully employed?

A. There is no question about that. The National Association for Retarded Citizens, rehabilitation services of the Federal Government, through my own experience and professionals that I know, estimate as high as eighty-five percent of the mentally-retarded population can be employed.

Q. Are there any programs or services recognized in your field to help the mentally-retarded citizens achieve gainful employment?

A. My experience and my basic reason for being here is my relationship and my experiences in working with adults; and in the work with the adult mentally-retarded, typically, sheltered workshops, work activity programs, modified skill-training programs, and on-the-job training programs with appropriate supportive services are some of the recognized techniques for making mentally-retarded people ready to enter competitive employment areas.

Sometimes the supportive areas, of course, there are certain kinds of supportive areas that I can get into.

Q. Will you describe what you mean by sheltered workshops?

A. Certainly.

"Sheltered workshop" is a term that was given authority and credential by the Department of La-

[6-96] bor, in which, during a training or an evaluation period for someone who is disabled or thought to be disabled, a wage-and-hour exemption certificate is obtained for the sheltered workshop or for the work activity program allowing a training wage which is

characteristically a sub-minimal wage to occur during that training or evaluation period.

Q. From whom do you get this exemption?

A. United States Department of Labor, Division of Wage and Hour.

Q. You also mentioned a modified work station. Am I correct?

A. Yes.

Q. Would you explain that?

A. There were different types of service delivery for those individuals who are mildly impaired or who have minimal secondary difficulties.

A regular working station, much as anyone in this courtroom could handle, is the norm but we find in working with the population that I see the mentally-retarded adult and the multiply-handicapped adult, modifications of work stations and work-training methods are indeed beneficial and increasingly more common.

We would use industrial techniques, such as industrial engineering, some electronic modification, hydraulics, pneumatics, utilization of even bringing in some of the medical service people,
[6-97] such as occupational therapists, to maybe modify a wheelchair, and then the industrial type of people designing jigs, fixtures, modifications for the work performance to enable the individual to maximize his earnings.

That's the real goal.

Q. Will you give us an example of a modified work stand?

A. Yes, certainly.

In our workshop in Wichita, Kansas, we have a large contract from a firm that manufacturers aquarium filters for tropical fish. This whole contract now has been broken down into ten work stations.

The individuals assigned to that work station, each and every one, are multiply-disabled. They are mentally-retarded, moderate to severe in level, and also possess cerebral palsy conditions, possibly epilepsy. Some have hearings impairments or are deaf.

These people are now able to perform in a work setting and participate at roughly twenty to thirty percent of normal productivity rate with the fixtures applied in modified work stations.

Prior to that time they could not perform at all.

We are talking about modification, less than five percent of the productivity rate of the normal worker.

Some of the modifications would include a method — in fact, we have now, in working with the
[6-98] Rehabilitation Engineering Research Department at Wichita State University, eighty different activation devices. We can actually start a drill press by biting on a switch, by pulling on a switch, by passing a hand to break a light beam, by passing a magnet over another magnet.

There are all types of ways to perform work and the challenge comes to those of us in this field of allowing disabled, significantly-disabled, people to participate in the work ethic, with the limits to them that if we can modify their work station they were to begin to participate in something we value — real work.

Q. You also mentioned supportive programs.

Could you tell us what supportive programs are?

A. In the field of rehabilitation, in community rehabilitation facilities, work is the theme and there is no doubt about that. That is the primary training vehicle, but supportive programs are needed, such as social service, such as psychological services.

Years ago, ten — fifteen years ago, we would

have received community referrals and the individual would be mildly retarded and there would be no other secondary difficulties involved.

Today, with so much of the institutionalization effort affecting community services, we no longer see someone who is just ten percent retarded. We
[6-99] see someone who is retarded and has emotional problems or we see someone who may be mentally retarded and blind because of Rubella outbreaks or so on.

So we actually need other kinds of services than just providing work, so we need occupational therapists, physical therapists for people who have cerebral palsy, and I mentioned psychological services if they are emotionally-disturbed.

And then training individuals to live, and to live in the activities of daily living, living skills are specifically taught. We have a program in our center which teaches how to ride urban mass transit systems.

Q. Is that what you consider a living skill?

A. (The witness nodded.)

Q. Where should these programs be carried out?

A. The ideal place for training, vocational training, job training, in the community, is where the jobs are.

Q. Is there any reason for that?

A. The world of work occurs in your city, my city, in our neighborhoods. It is the normal, expected place for work to occur.

We see people every day that are living in various living arrangements, but come to our shops or come to a crew that we have placed in industry for intensive short-term training, and we even have a
[6-100] program called Projects With Industry, where we bypass totally the sheltered workshop and the individual goes directly to the plant and we pay the em-

ployer a learning wage so that the person can train actually in the plant.

Q. Where do these people live as you are teaching these programs in the community?

A. Living arrangements would be as diverse as the living arrangements represented by the number of people here in the courtroom.

We have people, of course, living with their parents. I would say as many as one-third of our people still live with their natural parents.

We have some individuals whose natural parents have died and they are living with a sibling, a brother or a close relative.

We have several that are in what we call a small home cooperative. This is a chain of adult foster homes. We have forty to fifty of these at a given time with no more than three people per home.

We also have contracts with eight group-home facilities and in Kansas no more than twelve people per group home.

We have many others who are living in their own apartments or who are living in apartments where, similar to Miss Glenn's testimony, maybe a
[6-101] staff person is available and they can be checked on daily or they can be checked on weekly or whatever the needs requirements of this mentally-retarded person are in that setting.

Q. Is there a reason for having these people live in a community rather than in an institution?

A. Well, first of all, living in a community is more natural and normal and if you are going to participate in the world of work that's where it is going to happen.

It is not going to happen in the institution, it is not going to happen in the community; and in the particular population that I deal with I cannot even conceive of it occurring in the institution. It must occur in the community.

Q. Now there are institutions that are programmed that offer the type of programs and living arrangements that you have just described located throughout the United States?

A. Certainly. In my professional experience I have traveled some and I have seen vocational programs with living options and appropriate supportive services in every state that I have visited, varying degrees of sophistication, but from California to New York and from Minneapolis to Louisiana it is a coast-to-coast proposition.

* * *

[6-106]BY THE COURT:

Q. By that did you see people in Pennhurst who, in your opinion, could be trained at your facility for employment?

A. Absolutely. There is no doubt about it.

In fact, I would say that I saw hundreds that could be trained in a community facility.

THE COURT: All right.

BY MR. RIVERA:

Q. Does your facility serve any mentally-retarded citizens with added handicaps?

A. Without —

Q. With added?

A. With added handicaps? I am sorry.

Yes. Our agency is a statewide agency and we serve all 105 counties of Kansas and there are some fifty other facilities in the State that serve mentally-retarded adults.

We have made it our business and we specialize in serving the multiply-disabled, the retarded person, so it would be very common for us to serve a

[6-107] mentally-retarded person who also has cerebral palsy, a mentally-retarded person who has emotional problems.

I think the last statistics that I looked at, twenty percent of our total population in 1976 had epilepsy, six percent were blind or were significantly impaired visually, seven to eight percent had significant hearing impairment or were, in fact, deaf.

* * *

[6-122] Q. How many contracts do you have in total?
A. Over a twelve-month period we would be looking at some 400 different, contracts in our shops.
Q. Okay.

Speaking of one contract, which is your largest contract?

A. The largest single contract that we have is one
[6-123] that goes back some four years. It is a contract that we have with the Federal Government and we manufacture forty-three different signs, legends, and decals that all of us have seen, such as the U. S. Army, Interoffice Motor Pool or Official Use Only — all this kind of thing.

These are vinyl pressure-sensitive decal signs and forty-three of those signs are made exclusively by our agency.

In fact, we obtained those contracts under the Wagner-O'Dea — it has been revised now, the Wagner-Javita-O'Dea Amendment, which allows for severely-handicapped, severely, non-blind handicapped to participate in Federal contracting; and we have proved our product to both the Department of Defense, the Defense Supply Agency, and to GSA, General Services Administration.

Q. Speaking of these contracts, would you briefly describe the different job classifications involved in selling this contract?

A. First of all, we are one of the few agencies in the country that has taken the Government work and has assigned it in total to our work-activity program, and I think that's important for the Court to know.

Q. In other words, all the work is strictly done by your clients?
A. It is all done by our clients and it is all done by our most severely-disabled clients.

[6-124] The contract on any given day will involve twenty-five clients. Out of that twenty-five, ten are cerebral-palsy, three are blind, and the rest are mentally-retarded and I would characterize them as being just moderately severe in nature.

There are three full-time staff people in addition to that plus a production foreman and a contract procurement person and then the industrial engineer that I mentioned to you earlier that would help modify the contract.

We still job out the actual die-cut, the actual printing of the letters. That is done at a printing plant in town.

The product then comes to us already die-cut and our clients remove the excess vinyl, proof the letters, and make sure that like the centers of the letters, the O's, P's, the A's, the D's — all of those are removed.

Then they are bonded on a machine and they are laminated and they are cut into strips or into square like if it is a single letter or a single number. They are cut into a specific dimension.

It is important to know that we meet military specs throughout the whole process, and then they are inspected and counted.

We use very severely-disabled cerebral-palsy, mentally-retarded people to visually inspect and
[6-125] then we use blind mentally-retarded to count the units.

Then they are bagged and sealed and from that point they go to a department that does not have any disabled in it, and that's our Quality Control Department.

One of the reasons we have been able, in our agency, to get good contracts and keep good contracts is because we make certain that the contracted stuff that we ship arrives absolutely perfect if we can at all qualitate it.

In the four years we have had this contract we have never had a rejection and since 1975, late 1975, we have been on fast pay. We no longer have to wait for a Government inspector to come. They trust us to that point.

The volume on this contract, by the way, is about $230,000 a year, so it is large business.

Q. And are the job tasks involved in filling the other contracts similar to the job tasks you just described for this one?

A. They vary. We would have some job tasks that would be simpler and we have other job tasks that are quite complex, such as in your electronics area.

By the way, that's in our work-activities program also, and in our metal shop this also would be a more complex kind of job function.

We do have some skill-training. These occur in service and clerical occupational areas. We train for food-handlers, we train for custodial and janitorial
[6-126] workers and in office areas, not so much with — yes, we have. We have trained like a copier, somebody that can run a Xerox machine. We have also trained in the operation of mimeograph, duplicators, mentally-retarded young men and women who want to do those operations.

We also have some of our emotionally-disturbed trained bookkeepers, but that's really not germane to today's discussion.

Q. From your tour of Pennhurst were you able to observe whether there were individual residents at Pennhurst who were capable of doing such tasks as you just described?

A. Absolutely. There is no doubt in my mind.
Q. There were?
A. Lots of them.
Q. From your tour of Pennhurst were you able to observe whether there were individuals who could be competitively employed in the community.
A. Again, I would have to answer hundreds of them could be competitively employed that are currently living at Pennhurst.

* * *

[6-129] Q. Getting back to your tour of Pennhurst, what was the purpose of your tour?
A. I had basically four professional concerns in touring an institution such as Pennhurst.

I was concerned about the habilitative programs of the adult patients that might be there.
Q. Excuse me for interrupting you, but could you define habilitative for us, please?
A. I would define habilitative as a developmental process in which one's total life skills would be dealt with, either in unison or one at a time, in order to bring one to a level of productivity where he might be useful not only to himself but to his community.
Q. All right. Continue.
A. I was concerned about the habilitative programs at Pennhurst.

I was concerned about the environment of the
[6-130] institution.

I was going to also review traffic patterns and lastly I wanted to verify and see for myself the movement from the institution to the community — was this happening? If not, why not? That kind of concern.
Q. Were you able to evaluate the programming done at Pennhurst?

A. Yes. I visited Pennhurst two days, did an awful lot of talking and walking and observing and later reviewed records after they were given to me.
Q. I felt that in general the programs that I saw and the records that I reviewed illustrated to me that the programs for the adult mentally-retarded at Pennhurst were inadequate.

In my conversation with Dr. Youngberg and other assistants that I had, by their own admission they felt that the average program — by that I mean planned, meaningful activity, structured, planned, meaningful activity per day for the adult population in Pennhurst would be no more than an hour and a half per day.

This is a long way away from a six-hour requirement, which would be the Joint Commission on Accreditation of Hospitals requirements for a structured programmatic day.

* * *

[6-146] Q. And what observations led you to conclude the physical environment was, I think you worded it, substandard and dangerous?
A. Most of the buildings that I toured thorugh were buildings that were built fifty years ago, approximately.

They were not accessible. They were either
[6-147] very cold or very hot, and we are talking about steam heat that was extremely difficult to regulate.

We are talking about sleeping rooms with only one method of egress in case of fire.

THE COURT: That also happens in new buildings.

THE WITNESS: The environment was certainly lacking in any redeeming quality that I can think of.

I recall one ward where forty-six beds were shoved together in one sleeping area; broken furniture in the day room and sitting area and, of course, the residents were locked out of the sleeping area because there was not sufficient staff to maintain order.

On one ward when we walked in with Dr. Youngberg somebody had lost their shoes, so the shoe box had been brought out into the middle of the day room and all the shoes had been taken out and all the shoes were in the middle of the room and everyone was looking for a pair of shoes. They thought there was a sale going on.

I question very sincerely the safety of those buildings with regard to fire. There were a lot of clothing that could burn; there was paper and trash in some of the areas. The housekeeping was not that good.

In some of the wards I asked how often they saw the housekeeping people or if they had housekeeping personnel assigned to the ward; and I was
[6-148] informed in two instances that they hadn't seen a housekeeper in three days.

In both of those instances I think there were housekeeping personnel assigned to the ward but they just did not show up for work. There was an absentee problem in a very critical area and that is maintaining sanitation and order and cleaniness in the area.

Even in the new buildings — I visited several of the modular units and I think this is important too.

I liked the layout of the units and I thought they provided some privacy and they were bright and clean and I felt very homelike for an institution to build.

But I was informed that the construction of those things had taken literally years, that the cost override was phenomenal.

In the first modular unit we went into the residents reports that they had not had any hot water showers for three weeks, so even in the new units there were some real problems as far as just creature comforts.

* * *

[6-149] I ask you to turn to Exhibit Number 48, the picture log, Pictures Numbers 102 and 103, and ask you whether there is an accurate representation of what you saw in Ward D-1?

A. Yes, it is.

Q. Could describe what you saw in Ward D-1 now?

A. This was a ward with forty-six non-ambulatory males. Almost every one in that ward was in a wheelchair.

Total staff for all three shifts were only sixteen. On the date of my visit there were four people, staff people, present.

There were no meaningful activities whatsoever going on. There was a television set up fairly high that was blaring away.

The day room was in the center of the two sleeping rooms. In this particular ward the sleeping rooms were not locked, but the residents were prohibited from going into the sleeping area.

There again it is poorly lighted.

I was concerned about how four people could get forty-six non-ambulatory people out in case of a fire. I just don't see that the basic fire and safety code could be adhered to on that kind of a staffing situation.

Q. Did you find the other wards similar to this?

A. I saw other wards with similar kinds of conditions, except that this was such an acute case be-

[6-150] cause they were all non-ambulatory.

Q. In terms of the conditions you have already stated, did you find similar problems at Pennhurst?
A. Yes.
Q. Were you able to evaluate Pennhurst in terms of physical environment?
A. Yes, I did.
Q. What did you conclude as to the workshops?
A. Well, workshops are usually something like stepsisters. They usually get the building that is about to be razed or the basement of the school; and the room that was loose, and I was not disappointed in what I saw in Pennhurst.

We visisted Building U, which I was told by Dr. Youngberg is scheduled for razing in the near future.

That building is an extremely depressing old building that does not meet even the basic standards of human occupancy.
Q. I will ask you to turn to page thirty-five, Picture Number 68, and ask you whether this is an actual representation of the workshop you observed in U Building.
A. Yes, it is.
Q. Could you describe the deficiencies you observed in this workshop?
A. Again, we are looking at a building that was not accessible.

This could not meet even minimal industrial
[6-151] standards. The aisles and passageways were not clearly marked; in fact, it was hard to tell which was an aisle and which was raw materials or finished goods.

There was no storage area so the goods either coming in or going out were stacked in the aisles.

Many of the machines were not properly grounded, not meeting the basic OSHA standards.

Q. Excuse me.

Mr. Settle, could you please tell us what OSHA means?

A. Occupational Safety and Health Act.

Workshops are involved in interstate commerce and we are subject to all of the safety rules and regulations promulgated by that act.

Q. Thank you. Just continue.

A. Lighting in some of the areas of the shops was not adequate.

The restrooms were not adequate.

The facility, as I say, was subject to soon be destroyed and no money had been spent in ages on just building upkeep.

Q. During your evaluation of the workshop in terms of physical environment, were you also able to observe and evaluate other workshops in Pennhurst?

A. The other workshops were, as I mentioned, in the basement of I Building, on the main floor of the school building.

[6-152] These were small units that were set aside for prevocational purposes.

Q. And how do they compare to the workshops that you have pictured in Picture Number 68?

A. In all cases, they were not in accessible areas and there was only one method of entrance there, for egress, for ingress and exit.

Q. Any other deficiencies?

A. As a result of the placement of the workshops on the Pennhurst grounds, there would be extreme difficulty in getting physically-handicapped people into the workshops. There is just no space, there is no room, there is no ramp. The doors to the restrooms are to narrow.

* * *

[6-153] Q. Mr. Settle, does the fact that the workshops are substandard and unsafe create any additional problems?

A. There are a lot of spinoffs from such a situation. One, obviously, they were extremely crowded so that there were people who needed workshop experiences who couldn't get into the workshop.

Secondly, when you have people that can't go into workshops, I assume they are being held elsewhere and they may have programs or they may not and the consequence of that would be behavior
[6-154] problems because they didn't have meaningful work to do, a lack of training opportunity, a loss of earnings, and probably most important, because most clients out there claim that no one has to work.

* * *

[6-163] Q. Mr. Settle, do you have any recommendations to improve overall conditions at Pennhurst?

A. Let me refer to my written report on this particular matter.

I honestly feel that at this point there is no need for further admissions to Pennhurst because of many of the things that I was concerned about.

I would recommend that vocational rehabilitation in the Commonwealth of Pennsylvania immediately a very aggressive evaluation and training and replacement program be set up in conjunction with or independently and related to those Pennhurst residents who are nearing readiness for community integration.

I recall one interview with one of the former vocational rehabilitation counselors, who was a unit chief, who said there are only three vocational counselors on the whole staff — 1500 and some people and only three counselors, none of whom were

functioning as vocational counselors. That was a civil service title.

I am concerned about that. In order to move people vocationally you have got to have someone in there who knows how to play the game.

I would recommend that the residents at Pennhurst be programmed immediately into a ma-
[6-164] jor program for the major portion of their waking day. One and a half hours isn't going to make for the people who are going to be ready for community integration. It is just not that meaningful.

The staffing that I observed at Pennhurst is not adequate. Additional supervision is needed and more attention to housekeeping. Those two areas are immediate concerns and, of course, the whole area of programming needs to be dramatically improved.

This next one, I am sure, has one horrendous price tag, and that is I think that Pennhurst, in order to be a safe environment, needs to meet all applicable life safety codes.

I found one figure yesterday that $21 million would be the pricing and I begin to look at the cost benefit of what I saw for Pennhurst in this particular estimate and I don't know that it is worth it, a very personal opinion at this point.

I would recommend at this point that Pennhurst not build any additional cottages on its campus and deal very honestly and sincerely in moving and integrating people into the community.

Finally, I would recommend the absolute prohibition of any restraints or isolation in Pennhurst.

While in D Building I did observe records and I did see the isolation room and I just don't see that
[6-165] there is any need for the utilization of such behavior-restraint.

[6-165] Q. Mr. Settle, if Pennhurst was to implement all the recommendations you have just made in your professional opinion would the habilitative needs of the residents then be met?
A. I am afraid not. It would still be a large institution.

It would still be a very non-normalizing environment. It would be a situation where regimentation is the theme of the day, where people are referred to by case number rather than by name, where people have to wait in line to get into the workshop, where people have to wait to get a patient-worker job, because the team has failed to act and send a pink slip down to Mr. Ingalls.

Those kinds of things to me would indicate that we would still have a very, very large unnatural institution with all the problems therein. It is not a normal setting; it is not going to produce a quality of life that I would want to see happen here in Pennsylvania.
Q. And what do you mean by normal setting and quality of life? In what terms do you mean that?
A. We get into, I think, some of the same kinds of things that Miss Glenn was talking about.

The whole principal of normalization is to not treat mentally-retardeds as some strange creature that is markedly different from you and I. Usually retarded people I know are more like me than unlike
[6-166] me. They have the same needs, the same desires.

They generally can follow the same life-style. They live somewhere, they work somewhere. Most all of the people I know can use the same generic community services.
Q. So then, in order for the habilitative needs of the residents at Pennhurst to be met, they should be provided with the services they can get in the community?

A. The community is preferred.

Q. Mr. Settle, you have mentioned the community.

Have you had an opportunity to evaluate the various community services available in Pennsylvania?

A. Yes.

Q. When did you have this opportunity?

A. On February 24 and 25, 1977.

Q. Do you remember where?

A. (There was no response.)

Q. In what area?

A. I toured programs in four of the five counties in this region. In all four counties except Philadelphia County — Delaware, Montgomery, Bucks — and then I am neglecting the next one, I can't remember the fourth.

Q. Chester?

A. Chester County.

Those are the four counties that I visited programs in.

[6-167] Q. What type of community alternatives did you evaluate?

A. My visitations again were limited to looking at programs serving older teens or adults in vocational settings or in related living arrangements, so I looked at schools for severe, moderate, and profound trainable handicapped people operated by intermediate units.

I looked at sheltered workshops, several of those.

I visited a vocational technical high school, in which there were special classes integrated right into that building.

I also visited a corporation that operates foster homes and group homes for mentally-retarded. I also spent two or three hours one evening in such a home visiting with the seven ladies that lived in that home.

Q. Will you tell me the procedure you used in evaluating these various programs?
A. In almost every incident that I can recall I talked to either the program director or the executive director of the agency.

These tended to be either public-school operators or private non-profit entities.

I talked briefly about their program goals, their program philosophy, a little bit about who they were serving, where they came from.

[6-168] Then I reviewed records, I talked to staff, I talked to many of the students and many of the workers that I met in the community programs.
Q. In your professional opinion were the programs you observed or did the programs you observed cover the range of community services that would be necessary if Pennhurst residents were to placed within the community?
A. Yes, they did.
Q. What sorts of citizens were served by the various community programs you observed?
A. In my tour of the facilities in the four-county area I observed mentally-retarded receiving training in services from the profound level, such as the ones I observed in Summit School. I think there were about forty such individuals in that school whom I characterized as profound up through some very mildly-impaired individuals in some of the workshops and work-training programs.
Q. Were any ex-Pennhurst residents in the various programs?
A. Dozens. The majority of the people in the group home came from Pennhurst.

In the Bucks County workshop I believe twenty to thirty had come from — which would be a majority of that center at the time of my visit.

In the schools some, not large numbers of people, but some had been at Pennhurst.

[6-169] Q. As a general observation would you say that the Pennhurst residents were able to function within these community settings?
A. They were, yes.

* * *

[6-170] BY MR. RIVERA:
Q. Could you describe the program of the Summit School?
A. Yes. This was an excellent school. It was operated by an intermediate unit.
[6-171] It had, as I recall, about 180 to 190 students. All students in this particular program were fed into that program by other schools within that county district or within that intermediate district.

All of the people in this particular school had IQs under fifty, so we are talking about someone who is significantly impaired intellectually and we are talking also about a lot of multiply-handicapped people. I saw people in wheelchairs, deaf people, some who had visual impairment, some blind as well.

They served people all the way down to about three years of age.

In my conversations with Joan Beck, who was the supervisor of that school, the vast majority of these people lived with their natural families. A few lived in foster homes and I think she said three in group homes and maybe one or two in St. Edmonds Home or Hospital, I am not sure what it is called.

I just felt that it was a very, very well-run facility for a very severely-handicapped group of kids.

BY THE COURT:
Q. What was the address of that again, if you recall?
A. I don't know that I — as I recall — I am sorry, sir. Your Honor, I don't have the address on my tongue and I cannot recall it.

THE COURT: All right.

[6-172] BY MR. RIVERA:

Q. Do you remember what type of individual programs were being run within Summit School?

A. It was set up as a school, so they had various classrooms. There were several dozen special education teachers.

In addition to that, there was again almost for every teacher an aide, so there was, I find, an excellent staff in attendance.

Then over and above the teacher and your aide staff competency, they had specialists in language development, in speech and hearing, in sign language, in vision consultants, psychologists, and social workers. They had a nurse.

I felt that it was a very, very well put together professional team that could look at a child and assess his assets and limitations and work with the school and the family for a very good plan.

[6-173] Q. The next community program you mentioned was the training class at Central Bucks School; is that correct?

A. Yes. This was a new experience for me.

In our part of the country, in the Midwest, I have not visited that many technical vocational schools where trainable mentally-retarded, the people that again would be in the low fifty IQ, had been integrated into a vocational technical setting.

I went to this beautiful, brand-new technical-vocational high school located in Bucks County and was taken to the second floor classroom, which was right alongside of a lot of other classrooms, walked in, and met a teacher who had an aide, and he said that his capacity there would be about twelve students.

At the time that I visited his class he had nine — eight young men and one young woman — in his class.

He had a talk that lasted about four hours getting into communication skills, reading for living, and excess who go hot and cold and those kinds of things, so that a trainable person could begin to exist comfortably in our world, which is somewhat essential.

[6-174]

He got into some stimulative work. He got into a little bit of recreation and physical development and then the really surprising thing is something I felt was very exciting.

These kids then had a chance to go into things like auto mechanics, into horticulture, into cosmetics, cosmetology, and into some of the other manufacturing areas and actually get experiences with the normal student in that setting.

It was a real knockout. I thought it was a very normalizing, a very healthy kind of situation.

If the person couldn't handle it he could always come back to his home base. If the person had difficulty integrating into the class the teacher would send the aide to kind of work as a buffer and as an introductory person for the young adult.

I thought it was an excellent program.

Q. What about Bucks Vocational Center? Would you describe that program for us, please?

A. This particular sheltered workshop was one that I visited on my last day and it was located in Bucks County, in an industrial park, in a brand-new building.

Q. Are there any advantages to have such a vocational center located in an industrial park?

A. It is an extremely proper and normal place to put a workshop, where you get real work from the community; and having a workshop in an industrial park is exactly where it should be in my opinion.

[6-175]

Q. All right. Continue.

A. In this particular shop, it had been previously located in another area and they had just recently got-

ten additional funding and had rented this large area and had been serving, I believe, about sixty people on the day of my visit.

I was told that out of that sixty thirty had been in Pennhurst previously. I was also told that by July 1st another additional number of twenty were to be transferred to them.

BY THE COURT:

Q. From Pennhurst?

A. From Pennhurst.

Of necessity I saw, I would estimate, that about ninety percent of those were mentally retarded. They had a few individuals who were emotionally disturbed or blind or had some other primary disability besides mental retardation.

They had services in areas of vocational workshop, occupational training. They had some specific skill-training in food-handling and they had two others on the drawing board, janitorial and material-handling training, that I think by this point would be operational.

He had a staff of twenty-two and an annual budget of almost a half a million. It was a very, very
[6-176] well-equipped, pleasant, attractive environment.

BY MR. RIVERA:

Q. The last one you mentioned was Drexel Hill; is that correct?

A. Yes. This was a group home operated by New Challenges, Incorporated.

Q. Mr. Settle, could you look at U. S. Exhibit Number 48? I ask you to turn to page thirty-one, Photos 59 and 60, and I ask you whether these are an accurate representation of what you observed at the group home at Drexel Hill.

A. Yes, it is.

Q. Could you describe that program?

A. Well, it is a home in just a residential area, in which I observed seven women, I would say in their

twenties, who resided together. They were all unrelated.

They had one person employed by New Challenges who is functioning as the house manager.

The women in this particular home, seven ladies, all of them worked in workshops or in rehabilitation centers.

Four had come from Pennhurst.

I would characterize these ladies as moderately-retarded.

The important thing here is that they lived on a street like my street; they used public transportation
[6-177] to get to work; and they were all earning their own money.

They were showing me clothes that they had purchased with their earnings, television sets that they had saved money to buy, and some other really neat things.

The home's mascot was a beautiful Afghan hound, which everybody flipped coins over to take for walks. One of the girls upstairs had a couple of parrakeets and, believe me, you don't see this in Pennhurst. There would be no way to have such pets on the ward.

Q. Mr. Settle, before continuing, is the Summit School the one located in Wallingford, Pennsylvania?

A. That is correct, thank you.

Q. Mr. Settle, from your evaluation of all the community services, including the four that you just described, is there an advantage to offering these programs in the community rather than in institutions?

A. There is no question in my opinion the quality of life that these people enjoy in the community is far superior. They have many, many opportunities to learn, to observe, to model their behavior, to improve their behavior by associating with non-handicapped people in the community.

It is a tremendous advantage, I think, to be in the community close to one's relatives and parents.

I recall a conversation with Dr. Youngberg, where he said only maybe a third of the parents at
[6-178] Pennhurst were really actively involved with their resident out there.

Part of that is the isolation and part of it is what parents have to go through in order to institutionalize their retarded person in the first place. It is a little bit like somebody dying.

BY THE COURT:

Q. In your testimony you have indicated that several of these community facilities that you visited had a number of those attending who had come from Pennhurst.

A. Absolutely.

Q. Did you have an opportunity while you were at Pennhurst to ascertain why more residents of Pennhurst were not being funneled into these local programs?

A. There were several, several areas of concern, your Honor.

One would be the failure of the community to provide simultaneously both a place to work and a place to live, some kind of failure to coordinate fifty places in a workshop with fifty places to live. Somehow that doesn't happen.

Maybe under the same corporate auspices, or maybe the State's funding of those things —

Q. Do I understand that the facility which you operate has residents from areas provided by the school?

A. We do not operate in those directly. We contract with forty home operators and eight group operators.

[6-179] Q. In the vicinity of —
A. They are all over our county. Those homes are in forty-eight different neighborhoods.
Q. How do your trainees or students get back and forth?
A. Our Metropolitan Transit Authority — they use our State bus service, with the exception —
Q. In order to take advantage of your training facility they at least have to reach the stage where they are able to, we will say, live in one of those residences in the community and also to use local transportation?
A. We will match the person to the residence, and some of our residences prefer the workers very close to their work. They like that sort of dependable person.

Then we would actually train the person to ride the bus.
Q. I think I probably interrupted you when I asked you the question if you had been able to ascertain why more residents at Pennhurst weren't funneled into these local training programs and you had answered partially, as I recall.
A. Let me return to my thoughts on that.

I was concerned, I think, about maybe the lack of coordination between the development of vocational services along with housing. I see that as a real problem, not only in Pennsylvania but in my state. I see that as a common problem.

I also fail to understand why Project 256 has
[6-180] not been kicked off. There are millions of dollars that have been made available for it, for the Pennhurst residents to become integrated into the community and that seems somewhat slowed down or lost in the bureaucracy, and I would hope that whoever is responsible for the slowdown can build a fire under those people who can make it happen.

There is no reason why I can see why these dollars can't make room for hundreds of people in Pennhurst in the community, open those group homes, maybe talk about adult foster homes.

They can serve a lot of people for less money and provide very intensive, almost one-to-one, care on that kind of a basis.

Then, for every group of homes you open you could open some workshops and you need some case managers to make sure that these people have an advocate and get the services that they need to get and that the quality of the program in that home and that workshop is proper.

It is not that difficult; it is being done.

* * *

[6-183] Q. Let me just ask you a question.

In the various retarded citizens that you saw in community services, in your professional opinion as an expert, how many of these people that you observed would be potential Pennhurst residents if the community program did not exist?

A. That is an interesting concept.

A lot of the people I saw, for example, at Summit School — if it weren't for Summit School or something like that, I think the parents would have very few other alternatives.

If the community doesn't have answers for par-
[6-184] ents who have significantly-impaired kids, the only answer for it is the institution, so those facilities do prevent institutionalization.

* * *

Supreme Court, U. S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

**ON WRITS OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

JOINT APPENDIX
VOLUME III, A538-A694

**Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.**

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

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Testimony of Gunnar Dybwad

* * *

[7-50] MR. GILHOOL: Dr. Dybwad has been qualified as an expert in mental retardation, in the care and treatment of mentally-retarded people, in the administration and management of residences and other services for the mentally-retarded, and the sociology of the families of the retarded and in the comparative aspects of such matters across nations and across decades.

DIRECT EXAMINATION

BY MR. GILHOOL:

Q. Dr. Dybwad, have you visited Pennhurst recently?

A. Yes. I spent March 19th from about 9:30 to 5:30 in the afternoon at Pennhurst.

Q. And what wards of Pennhurst did you visit?

A. Well, I have a map here. I visited about half of the buildings and maybe about one-third of the wards.

Q. Did you visit the modulars?

A. And every one of the modulars, two wards on the
[7-51] New Horizons Building, one ward in the hospital, Q-1, D-1, D-2, T-1, W, M-1 and M-2.

Q. Have you previously had occasion to visit Pennhurst?

A. I have been in Pennhurst over the past fifteen years on various occasions, some specifically to visit; others because there were hearings or other meetings there, so I have been there at least six times.

Q. And what was the distribution of those visits across the last fifteen years: In what years?

A. I think they were more frequent in the 1960s, particularly the second half of the 1960s, when I was very much involved up there.

Q. When was your last visit before this 1977 visit?
A. I think it was either in 1969 or 1970; I am not quite sure.
Q. How, Dr. Dybwad, does the Pennhurst of 1977 compare with the Pennhurst of the late 1960s and before?
A. Well, of course, there have been changes made, some new buildings, and certainly some of the worst conditions of the late sixties have been improved.

You no longer find the kind of extreme unfriendly conditions which one found in those days, with feces around. I certainly found, for instance, the toilets are much cleaner. I even found soap in two of the wards.

From the outsider's view I looked at some of the refurbished wards. Pennhurst does look not quite
[7-52] the same as it did in those years.

But I have learned, as I look at institutions, and I do so with fair frequency, I try to look through the eyes of the residents, the residents' perspective; and from that viewpoint you still have a stultifying and essentially a dehumanized environment.

There is no visible wall or fence around Pennhurst, but it is certainly an invisible fence; it is a segregated community. One is in there, shut off from the world.

I know that some people have passes to go out, but essentially it is a closed institution with an environment where some of life's most basic satisfactions — eating, for instance, still takes place under very unsatisfying circumstances. One's senses are still being assaulted — the smell, the noise, the visual distortion — and this, you see, is for the very people who are in Pennhurst supposedly so that they develop to have a basic sensitive experience.

The noise level, which assaults, of course, staff as much as residents, puts really a burden on every-

body. Getting used to it means you continually scream to get on top of the noise. It really lowers one's expectancy.

From the sight viewpoint it is still an ugly place. The hallways, the inhuman dimensions of the spaces where people are supposed to live — the hallways, the corridors. It is more like a bus station
[7-53] than like a place where you or I live.

It is clean, but that does not change — a clean bus station.

Crowding has continued to be a very serious problem, I know. I know that much of the present crowding is doubling up while part of the institution is renovated but again, you see, from the administrator's viewpoint and from the outsider, that's an acceptable explanation.

But for the people who live there doubling up means that they are twice as crowded than they used to be, and there is very little comfort for the person who lives in those circumstances to know that sooner or later somebody else will be in a repainted and refurbished place.

Q. What about the activities in 1977 there as contrasted to previously?

A. Very much in evidence now are activity charts. You find them —

I always try to visit offices and not just the wards and you find in every office there hangs a wall chart with activities, and certainly there are activities listed there which one would not have found at the time of my last visit.

But when you look at individual residents — and what I do in such cases is that I notice some-
[7-54] body on the ward and I say could I see the particular chart? Then you can find it and when you study the ward chart, while you find there are activities on some, particularly some of the wards, there are a

good number of people for whom there is either no activity but a minimum activity.

Now I visited on Saturday, so I was not able to actually go out with the group and see what kind of recreation was involved when it said recreation, or what kind of therapy activity.

But the activity on the wards I could observe and that is still inactivity. There is very little that actually is going on, or to some extent it is really destructive activity, either by its acts of nature or by the total inactivity. In other words, you can be inactive huddling in a corner to such an extent that it is really destructive.

I don't want to make too much of incidents because, you know, they happen continually when you have such a large group of people, but in one ward, which happened to be on M-2 in Unit 5, there were a group of young, obviously aggressive persons, and one of them just kept on hitting another. The two attendants were really helpless to handle the situation until they decided to divide the group, and the woman took a group of them outside, which left the man with a smaller group.

[7-55] But on this ward at that time we visited there was absolutely no activity. You might say the only visible activity was this one boy.

So on the wards, the ward situation is still extremely unsatisfactory. Outside of the television you really see no visible signs of activity that could be carried on.

Q. Were many people outside on that Saturday?

A. A rather few. I just said the ward attendant took a few of them out, but as we walked around the grounds, and we covered a lot of territory, no one could see — and it was a Saturday, and in a way I think more people would visit institutions on weekends. Weekends for us are recreative days. I mean

we play golf or bridge or read books or go to movies or listen to good music and so on. In institutions, of course, they are the dreaded days with a curtailed staff, a minimum of activity, and outside of those fortunate few who have visitors, Saturday, indeed, is a dreary day.

I will admit I visited Pennhurst at an unfavorable day but again, you see, from the viewpoint of the residents there are fifty-two weekends in the year and this is the kind of routine.

Q. You mentioned some physical changes, improvements at Pennhurst, between the late 1960s and 1977.

What were your observations with respect to those?

[7-56] A. Well, the most disturbing visible improvement is a new building called New Horizons, which is really almost a travesty because it is a throwback to the worst of institutional architecture. It is the last building outside of the modular things, and this last building is an architectural atrocity beyond redemption.

There is nothing you can do with it. It is laid out in such a fashion that the living spaces, the dormitory spaces just can't be changed.

You would never think of human beings living there. You might store things in such a building and so on, but it has no connection, it is built solidly, although I believe there were some technical problems before it was opened.

But to me right now it looks like a solid building. Technically, you would have to say this is an improvement, a new building has been put in place.

Again, from the point of view of the residents, it is a totally unacceptable environment. There is nothing human about this — the floors, the walls, the total sterility. It is a mechanized environment. It

is out of the human scale, and to me, who has worked in the field of architecture for a good number of years, it was a very sad commentary on what we think of people who live in these institutions.

[7-57] Q. What of your observations of the modular units?

A. The modular units architecturally are quite acceptable. Again, I know that there were some technical difficulties about their opening but architecturally, although I wish they would have been duplexes, that they had cut them in half and made little, smaller units, but the rooms are all right. The general appearance certainly is on the human scale — single, double rooms, some sitting rooms and so on, some nice sitting rooms and so on.

But I was reminded of something that happened some years ago in Idaho, at a training school, following a visit of Mr. Bump Nicholson, who is the Danish Mental Retardation Director, and some later visits by me. The superintendent, a pediatrician, decided he ought to get some smaller units. He did something we could never do here in the East.

He just went to a local contractor and bought eight houses, prefabricated houses, and put them on concrete platforms and used normal human housing.

It was a great achievement, but the satisfaction didn't last long because the staff said if they can live in these houses here on the grounds, in this isolated environment, why don't they live in such houses in the community? Why did we build them here?

I am telling this to point out that, of course,

[7-58] what is wrong about the modular units in Pennhurst is that they are on the grounds of the institution, part of the institution, engulfed by the institution, so when you went through a good number of these potentially attractive places you found rooms that were barren.

There was furniture in them. One room looked like the other, really, no visible signs that people lived in there, no family photographs and so on.

The kitchens in there — the food is brought in and I always like, again, from the administrator's viewpoint, to judge by the menu the dietitian submits. I like to take a spoon and taste, and always after permission; so in these new houses, this new home environment where great effort has been placed, the food was cold as it came in and I had it before the residents did.

So obviously, even within the modular units, there are the problems that are forced upon them because of the problem, and I am fully sympathetic, of a dietary department to cook meals and deliver them all over the grounds. This is what you are getting.

You asked me about the modular units. I wouldn't just say too little too late, but in the wrong place, in the wrong place.

Q. Dr. Dybwad, you first visited Pennhurst in 1959?

A. Well, it may have been earlier, it may have been.

[7-59] Q. Have you, has your criterion for judgment of Pennhurst and such institutions changed in the interim?

A. Oh, yes. Oh, yes, definitely, and I have to explain this because I have written quite a bit on the subject and I have to eat my words, and it is a steady diet.

All in all my comments on Pennhurst are much harsher today than they would have been five years ago or thirty-five years ago, strange as it may seem, because a lot has happened and the reason for this is that I have grown more and more intolerant of the institutional environment in proportion for what I keep on learning about the developmental potential of mentally-retarded persons.

In 1959, when I did begin writing extensively on the reform of institutional care for the mentally-retarded, I still believed that environmental and programmatic short-comings could be remedied to a sufficient degree that it would benefit the residents, and the sufficiency of that degree has something to do with my perception of the potential levels of functioning on the part of the individuals with severe and profound mental retardation.

My expectation for these individuals in 1959 was so low that I found it a quite adequate answer if you would just have a little smaller institution, smaller wards, more humane surroundings, maybe get rid of the tile and have more normal wall
[7-60] coverings, more normal drains in the middle of the floor, more activity. These schools to me seemed quite reasonable and adequate.

But since 1959 I, and I think a good number of other people, have learned a lot and much of the learning has come, interestingly, not from learned colleagues or books but from the mentally-retarded persons themselves by their ever-ascending level of accomplishments.

And this is particularly true with the group we refer to as profoundly retarded. They have been particular subjects of a lot of misinformation. Let me exemplify it.

A good number of years ago I read in the English literature about a young man, profoundly retarded, — idiots they are still called in England — who had been able to be placed in what they call over there a hostel, a large group hostel. He was interested, and I have, on each one of my visits — and I visit England practically yearly — made it a point to see this young man. He has a mental age of two. He has no speech whatever. He is physically handicapped. There obviously is a brain injury.

He is the kind of person who would be lying around in most of our institutions, or who used to lie around, and yet I have seen this young man, as I say, yearly. He is dressed like other human beings. He lives in a community residence. This is now at least seven years.

[7-61] He participates very inadequately in a workup program. Unfortunately, that's the only place they have, so they cut a little niche to keep him busy. He is one of the persons who can't be productively employed, but he can be engaged in activities and he is.

The main point is that when last I saw him a few months ago I saw him in the dining room at the head of the line, with his tray, ready to go and have his lunch, which he was eating in a small dining room in this workshop with the rest of the young men and women.

I also went over to the hostel and looked at his life there. He is a human being and when you see him he might attract your attention. His motions are slow, you see, maybe a little vacant expression, but it was less. You see, he lives, a very limited life to be sure, particularly since he was, so to speak, rescued. He was supposed to have been committed to an institution and somebody intervened.

He never had any kind of training throughout his adolescence, so he is extremely disadvantaged, but is this type of a person who is able to live in better surroundings and, of course, that depends on the stimulation of the surroundings.

Now I know, and I want to make this point, that in our institutions a lot of training is going on and I am very interested in new behavior-shaping procedures and so on and what good schools and institutions very often have as the program.

[7-62]

But the horrible thing is once they have gone through the programs they go back to the wards. We have trained them to live like normal human beings and excellent work is being done, I want to emphasize this; but then they go back to the ward where they sit on toilets without seats, six in a row, no privacy, in places that just don't smell, don't look like normal habitation, so it is from this viewpoint — it is from this viewpoint that I am sorry to say that Pennhurst just won't do.

Q. Dr. Dybwad, you have visited institutions in forty-nine of the fifty states and in thirty-five countries many, many times; is that correct?

A. Yes. I never got to Alaska.

Q. Will you tell the Court how Pennhurst compared with other institutions around this country?

A. I think on any rating scale Pennhurst would be in the bottom category, joined, unfortunately, by many such institutions, certainly by every one in my own state of Massachusetts, certainly by most of the institutions in New York State, notwithstanding the twenty-five or thirty thousand dollars per person that they are spending now.

The changes, of course, that have been made in Pennhurst have been made in the other institutions too because they have had an increasing pressure partly from federal reimbursement, partly because state health departments have become concerned and so on.

[7-63]

Much of the changes have been in the sanitary area and we have better health protection, better fire protection, the condition of showers and all.

You may recall that in Pennhurst we had some sad history of people getting in horrible accidents around showers and so on. These kinds of things have been remedied.

But when it comes to the basics, still all of these institutions are characterized by a very limited program, and for at least some of them that is too kind a word. They still have basically the kind of dehumanized building which differs totally from the kind of building you and I are using or they could use and do use in the community.

They still are characterized by an isolated location, by the size of the institution, and by the essential character of what government calls a closed institution.

I think there is increasing realization not only in this country, but certainly in those countries like England, which have this condition of large institutions.

Some of the more backward countries are far ahead. They never had the large institutions; they can move much more rapidly into something else.

There is growing realization that this is not the
[7-64] kind of place for people to live in. It is depressing, demoralizing.

I want to make this point because I have worked myself in institutions — depressing and demoralizing for the staff too to live with the smell, to live with these masses of people, to live with the noise, to live in this deprivation; so I, of course, am sympathetic to the staff.

It is just that the main weakness is that these institutions, by dint of things that I have mentioned to you just render human beings and habilitation very difficult if not impossible.

I have been an institution man since 1929. I come from the prison field and I worked in reformatories and juvenile training schools and then essentially, since 1938, in institutions for the mentally-retarded; and I have left so many, many changes, and until recently I remained really seduced by what I thought we could accomplish.

I always — you know, I organized in 1966 an international architectural committee and have been very active trying to help the states. Interestingly, it wasn't the bad conditions and our inability to do much about them which have changed my mind, but it has been the repeated and even more evermore impressive demonstration by children and adults with mental retardation of their capacity to live and grow, once we keep them free of the depressing institution-looking environment.

[7-65] You see, as long as I could blame the bad conditions on the institutions my energy and that of my colleagues was geared to two remedies — carpeting, better wall covering, all of these things, more staff; but now our energy is really directed to the creation of liberating human and humane environments in the community with the final objective of closing down institutions.

And I want to tell you quite frankly that it is my absolute conviction that we are seeing the last years of institutions. To spend in New York now $33,000 a year — the rates are going up continually — for what everybody agrees is inadequate care, is becoming, not just from an economic but from a logical point of view, an absolute impossibility.

But my main point is we now know we don't need these institutions.

Q. Do you have an opinion, Dr. Dybwad, on the question of whether varying the size of institutions or staff ratio or the rest can significantly change what happens at those institutions?

A. Well, I think studies have been made now, and interestingly, those in the field of vocational capacity of the mentally-retarded and in the field of institutional management, the British have been far ahead of us and so certainly we have studies from England.

[7-66] They started out with Jack Tizard in 1958 and a

group of youngsters out of an institution — hostels they called them — in London and placed them in small residences.

I was able to visit him in 1958 and saw his experiments and he and his colleagues — Dr. King, Dr. Rains, and later Dr. Cushing — have continued to lay the groundwork for looking at institutions from a different standpoint.

Now some people in the United States become interested and said can't we do this if we simply cut down the size? So recently three Americans — Bella, Butterfield, and Zigler — all Yale-related — studied four institutions with strikingly different populations, from a few hundred up to two thousand, and also with quite different per diem expenditures, so there were some good institutions in quotation marks and some not so good ones.

Yet they all showed the same similarity. The institutional cult, as people called it — it is really not a good word, it isn't much culture, but the strange patterns of mealtimes and of sleeping and of the non-verbal, the non-expressive life that characterizes people in institutions.

There was some growth, but a very slow pattern of growth; and later on Zigler and some other of his colleagues even compared the Swedish and
[7-67] American institutions because the Swedish institutions are just the same though maybe there they can find institutions who will give us the answer.

But again they found that when you compare institutions of whatever size — of course, typically, in Sweden — we have larger — forgive me, we have smaller units, smaller institutions. When you compare them with the kind of informal community residence, then you discover that the institutions are characterized by gross deficiencies in the quality of life.

In short, all these studies show that the quality of human interaction between residents and the staff and between resident and resident are really the key factor. It is not very surprising. After all, education — everything we are is human interaction, but it is interesting that even if we cut an institution of three thousand down to three hundred, which is a monumental task, people have tried to do so and are not even halfway there, we are still having this problem.

Again, I say, even if we install carpeting and Simmons mattresses and increase the staff, improve the training, we still come up against this terrible problem of creating a human dimension in an institution.

Q. In your opinion, Dr. Dybwad, is Pennhurst the least restrictive setting in which the people there can live?

[7-68] A. Let me answer this rhetorical question with a no.

Q. Is it the least separate setting in which the people there can live?

A. No. Of course, I realize that everywhere we are growing in this country and some of the extreme isolation of our institutions has been removed, but essentially Pennhurst, of course, is a separate place. As I said earlier, there is no visible fence around it, but it is fenced in.

It is a place that is separate by the way people live there during the day, by what they do, by the way they are dressed, by the way they walk about. It is a separate place for human life which sets it clearly apart, and I think setting it apart would mean separateness.

Q. Is it your testimony then that all the people at Pennhurst, including the severely and profoundly-retarded and multiply-handicapped can live an inte-

grated life in the community and need not live in such separate and isolated environment?

A. Absolutely, no question about that.

Let me quickly point out that usually people are going to say, "But what about those in the back ward, the people who are moderately handicapped or profoundly retarded?" I can move them out quicker than any other people.

Q. Why is that?

A. Because what they need basically is a small stimulating environment in a situation where their
[7-69] physical needs receive attention and, by the way, whether they will get adequate medical care — and I think I can state without fear of being contradicted that throughout the country the medical care in all institutions had been atrocious. It has been documented in medical journals. We haven't been able to provide decent medical care.

Take any group of thirty records at random from any institution and you will discover conditions that have not been remedied, that have not been — it appeared that somebody wasn't there and so on.

Q. How does residence in the community affect that condition?

A. Well, let me point out maybe here what I mean by community placement.

One of the more forward-looking states at the moment is Michigan. Michigan has taken such individuals from institutions and others from the community, people who we would call in the old institutional parlance crypt cases; has placed them in individual foster homes, not just a few of them. I am speaking, for instance, because I know it very well, of Macomb-Oakland county. Macomb is the county around Mount Clemens. This little area has 140 of such homes and I made it a particular point of asking about it very recently.

More than sixty percent were profoundly-retarded individuals and more than eighty percent were highly handicapped.

[7-70] How do they do this? First of all, they pay a decent rate of board and room and no longer expect such citizens to subsidize the state, as it has been in the past. I come from the ( ) field. We always expect the foster parents to subsidize the state because they are so afraid, the state, that you might make some money; but now Michigan has done something very simple.

It says to these people, who are, of course, carefully selected, look, this individual has the following needs and these are the priority programs for him. Will you undertake one of these programs — toilet-training, maybe; feeding stimulation, physical exercise under supervision of the physical therapist.

There is a wide range of things and they get paid for it; and for a fraction of institutional costs every day — usually it is, of course, a woman — the woman — I have been in some of these homes — will work for one hour. Now how many people in our institutions would get an hour's actual individual attention in any one of these remedial programs?

This has been going on now for a sufficiently long time and, by the way, in Macomb-Oakland now they have, because the powers that be, not just in this state, when we built the New Horizons, but practically throughout the country, are still building-oriented. We always build buildings and in Macomb-Oakland they were supposed to have an [7-71] institution of six hundred and Dr. Rosen, the director, got it reduced to ninety, so he has ninety beds available to him.

In the past three months he had reason to once admit a person from the community for two days. Otherwise they have completely liberated them-

selves there. The population is about the size of Philadelphia.

Q. Is the idea of severely and profoundly-handicapped and retarded people living in the community a new one?

A. No, of course. Many parents have kept them, have had them home. In London I have seen for long — many years ago already — they had special-care centers. The people lived at home.

London, when money never was plentiful, felt it was good economy, actually, for some of these youngsters to call by ambulance and bring them to the day centers, to the special-care centers, forgive me, and bring them back in the evening; and during the day these youngsters had attention by physical therapists, developmental specialists helping with their development and so on.

Now, of course, we always had such people live in the communities.

Q. Has the experience of such people in the community, whether always there or returned from institutions, been subject to study and evaluation over the years?

A. Yes. Probably one of the most interesting studies in our country was the study by Sanger entitled, [7-72] "The Adjustment of Severely Retarded Adults in New York City."

Q. And when was that study?

A. He made the study in 1957. New York City was one of the cities in this country with very early classes for children below the so-called educable level. They were called low IQ classes.

He, with generous support from the State of New York, identified over 2,000 of such individuals who had left over a period of twenty years, and they took a sample of conduct, that we followed closely with the help of the social staff. The surprising re-

sult was — mind you, there were days when we had no community services, we had no support services, parents had no help whatever, we had no community mental health centers or anything like that.

The surprising result was how many of these individuals somehow managed to live at home, were out on the street; how few of them had gotten in trouble. We always had visions of that individual either becoming criminally involved or sexually involved and in neither dimension was this so. They had maintained themselves.

Of course, a good number of them eventually went to institutions but more than half had remained in the community.

The interesting thing was the older they became the better were their adjustments. In other
[7-73] words, even with the adults there was a continuing ascendancy. They became older, they become more mature.

I have another theory about this. They look older as they, you know, look a little bit more adult. With the first gray hairs they were treated with more respect by the community, which was sort of a changing factor.

THE COURT: I haven't noticed that difference myself.

THE WITNESS: The counsellor didn't mean it.

So that, yes, we have such studies. An earlier one was made, as a matter of fact, very early in this century by Dr. Tunnel, who was superintendent at the Tunnel School in Massachusetts; really, he recanted, he recanted publicly.

He hid the study for several years; he couldn't believe it.

BY MR. GILHOOL:

Q. What was it that that study showed?

A. Well, again, the same, that the individuals whom he felt had to be locked away because they were dangerous to Society on the one hand and, secondly, in danger and in need of protection from Society, that they were making out quite well in the community.

So I think we have to recognize that in the category of the center that is below the capacity of — inactivity day centers we have throughout the country, thousands of such people below the educable — [7-74] not below the educable levels, I want to emphasize that. I am not talking about that — walk the streets. Some of them use public transportation and we have had a minimum of problems about them, but thereby hangs, I think, an important tale, and that has something to do with what we have learned from Scandinavia.

When, as a result of President Kennedy's emphasis and his sort of mentioning of Scandinavia, a lot of our people interested in mental retardation came to Scandinavia and looked at the institutions and always asked to see the findings of the severely-retarded. They came back and said they never showed them to us.

The point is they couldn't recognize them. They had a haircut, they were decently dressed, and they ate with knives and forks and they lived in normal rooms.

I well remember one of the Scandinavian directors told me about an American gentleman from one of our institutions, and a very good person, who visited an institution, noticed a window, and he said well, these windows can be opened.

The Scandinavian man said yes.

But they can get out the window.

And the Danish fellow said yes, they can, but they usually use the door.

[7-75] You see, we have in our country not yet developed to understand the history of Danish architecture. We have got to realize that we really had a position which is reflected in the way the individuals were handled, that this was a deviant sort of pseudo-criminal group, if not active potentially criminal, which had to be restrained.

We always built our institutions like this. We built windows so high one couldn't look out.

What the danger was about them, and always with small little spaces there, with metal in between, and I had a very constructive experience. When I had come back to Massachusetts with some series of slides from Denmark and Sweden and I showed them at the Tunnel School, there were some of the older medical people there and some other staff and the doctors said well, nice, nice, but it would never do here because they would break the windows immediately; you ought to see how many windows we have broken.

And the matron spoke up and said well, she said, you know, the west window, which has a nice view, has never been broken — a tiny little observation, but it really had significance. This was a building — Terry Hall at Tunnel School — a maze of tile floors, tile walls, drains in the floor, which was in itself an incitement for rioting.

I have watched, Counsellor, in Connecticut a kind of a ward like this being transformed. New furniture was bought, flowerpots were put up and so
[7-76] on, just to show what they would do with this kind of thing; and nobody broke anything. Destructiveness decreased.

In Sweden we transferred a group of profoundly-regarded individuals — I am talking about that particular group now — from the typical old institutional situation to one where they lived in nor-

mal beds, had small rooms, carpeting on the floor and so on; and they measured the success in interesting ways.

They weighed the linen changes, they counted the number of changes in clothing; and they found that the people no longer would soil their beds, that they wouldn't soil themselves and require change of underwear and more than just underwear.

They literally proved that the behavior changed with the change of environment.

Q. Then your testimony is that all of the people at Pennhurst can live in small-scale places in the community?

A. Absolutely no question about it, with, of course, the qualification that some of those who need acute medical care, like the rest of us too, may have to spend some time in the hospital, obviously.

When I think of community care I mean living spaces such as we are using. For some of them it may be an apartment. For others it may be a community residence; and for others, a situation where
[7-77] they can get nursing attention and so on.

But the degree of impairment does not necessitate their remaining in an institution. As a matter of fact, I again point out it is harder for them to get adequate care in Pennhurst or all my Massachusetts institutions than if you live closer to the community where good medical attention is available on a much more informal and more normal basis.

Q. So that your testimony is that the residents in the community, living in small-scale facilities, make many things possible —

A. Yes.

Q. — for their growth and development and the rest?

A. Yes.

Q. Is anything further required in your opinion to assure that the possibility is realized?

A. Well, obviously, as the institution and the administrators, as its compactness, you have one superintendant you can hold responsible if anything goes wrong. You call him up and say, "Doc, what's going on?"

Obviously, if he disappeared into the community we need some new mechanisms, but some of them have already been developed. Monitoring is of the essence.

I remember very well Goldman — wasn't that the name of the Commissioner of Mental Retardation in Pennsylvania? — who wrote a strong memo-
[7-78] randum to his superior pointing out that the whole Pennsylvania program would be in jeopardy unless you put in place the proper monitoring.

Let me say, by the way, I am not just talking about watching that nothing untoward happens in those particular names. That, of course, we ultimately have to see — that the people who contract live up to what they contract for; but when I speak of monitoring I also think of somebody making sure that the plans worked out for certain individuals, which goes, of course, beyond the residence, are actually being carried through and this kind of monitoring is something quite different, you see.

Furthermore, I also feel — and as a State employee I have great respect for the State government. I have spent years in the State government, but nevertheless I like State government to have somebody to look over its shoulder, so I am not content with merely monitoring by State or the local government, since these are two separate levels, but I want the informal citizen system where this can be done by having a board to take care of this.

I also hope, of course, that we can establish, as, of course, more recent federal legislation is actually anticipating, an individual advocacy relationship for

people of a certain degree of handicapping condition, not the mental retardation.

Q. What are the functions of such a relationship?

[7-79] A. What are the functions? Well, of course, —

Q. Is this relationship commonly called the citizen advocacy?

A. This would be something like citizen advocacy, yes; and this may sound sometimes a little bit more formidable.

Citizen advocacy is a good term to use with a twenty-six-year-old retarded man. When it comes to a youngster I still call it, I mean the technical term is all right but it means somebody who knows the individual, knows his needs, and somehow has been informed what steps one can take, what mechanisms are available, because every state has mechanisms of appeal and requests and so on to make sure that the individual gets his needs fulfilled.

The kind of looking-after for a child, which, of course, normal parents would do, but I certainly agree that with the profoundly-handicapped child very often it may be beyond the parents' capacity to marshal all the forces that are needed to help.

Q. Do you know, sir, that eighty percent of the approximately 1,254 people who are at Pennhurst presently went there when they were aged five to twenty-one?

A. Yes.

Q. And that since 1971, when admissions were technically, theoretically closed, another 200 people have gone there, most of them children?

A. Yes.

[7-80] Q. Why is it that parents and relatives can consign people to institutions like Pennhurst?

A. I think parents very, very often have absolutely no choice. It is not a decision they make; it is a decision that is forced upon them to some extent by peo-

ple who are convinced such individuals ought to be segregated.

In other cases, because parents have asked for help and the problem, of course, gets worse, the management of a child who does not receive adequate supportive services, and the management of the family with the child who doesn't receive adequate supportive services is getting worse and worse until finally the parents reach the point where they need to make this decision. They think — I have always insisted that institutional waiting lists are not waiting lists for people who want to get into the institution, they are waiting lists for non-existing community services or for community services which don't exist in sufficient degree.

Q. And you get —

A. I think you will find they have made studies about this. You made a study in Pennsylvania and when you asked people on the waiting list what they really wanted, and those who, in spite of existing situations at institutions, were quite far down the list, I think, if I remember correctly, they were asking for community residences and for vocational work.

That's, of course, a problem for many of our
[7-81] parents of all the children now — they look beyond school, what will happen then.

They didn't ask for what was probably the most important thing that we could render, but how can they ask for something they really don't know that it could exist, and that is help to the home because if you have early help rendered the parents in the home then the management of the child becomes so much easier that a lot of the severe problems never develop.

* * *

[7-82] BY MR. GILHOOL:

Q. Dr. Dybwad, did you participate in the planning

of a community service program for residents of Pennhurst and others in Southeastern Pennsylvania in the late 1960s and early 1970s?

A. Yes, to some extent I did.

Q. Would you describe your participation?

A. My participation in Pennsylvania mental-retardation affairs goes back about twenty years, but with particular attention to the Pennhurst situation it probably coincided with the possible expose in 1965. It was coincidentally at that time that the comprehensive mental retardation plan for Pennsylvania was published, one of the first in the country, resulting from Kennedy legislation.

[7-83] I had served in the Kennedy administration as a consultant when this came about, so I was involved in this and again this mental-retardation plan, with a corresponding mental-health plan, resulted in the 1966 legislation of the Community Mental Health-Mental Retardation Act, which was one of the earliest of such acts, and really began to focus on alternatives to institutional care.

It was at that time that I volunteered my services to the Pennsylvania Association for Retarded Citizens as a consultant. I had established good contact with the leadership while I was the National Executive Director of the National Association for Retarded Children, so during those years I made very frequent visits.

I remember that I analyzed for them the regulations which were drafted over a long period of time with regard to the MH-MR Act of 1966, and then later in the sixties I testified before both the Como and McGraw committees of the State Legislature, and their report led to Act 256 in 1970 — now I come to the point — which made $21 million available for community facilities to free 960 Pennhurst residents and allow them to live in the community.

There were difficulties about this and I participated in meeting with the Governor and the Secretary of Welfare and then, in 1970 and '71, I assisted the then Commissioner of Mental Retardation with
[7-84] assembling a panel of thirty experts among the many architects with regard to the implementation of this Act 256 and to take a look at the statewide picture of institutional facilities.

I remember it was at that time that Architect Gray of New York, whom I had brought to Pennsylvania, presented a very useful statistical formula which showed at what point it was futile and financially unbearable to repair old institutional buildings.

Well, I think this was about the core of my activities.

Finally, your Honor, I worked closely with the Pennsylvania association in the preparation of the right-to-education suit, but I had to forego the pleasure of testifying. You cut off the testimony, but that was a very definite involvement with Pennsylvania, so I —

THE COURT: We didn't know what we were missing when we did that.

BY MR. GILHOOL:

Q. Dr. Dybwad, in your opinion could Pennsylvania have provided residences and services in the community for all of the people then and now still at Pennhurst many years ago?

A. Well, in 1971 I would venture to say there was no other state as well prepared to arrange for community placement of persons from the institutions as was Pennsylvania.

Q. Why is that?

[7-85] A. Well, first of all, it had, in comparison with many other states, a vastly better structure due to the 1966 legislation. It didn't have just the county of-

fices everywhere, but in addition it had organized Base Service Units — at least a system was set up of Base Service Units which really made for a potentially effective delivery system.

The problem is do you have a service delivery system. Pennsylvania, with its Base Service Units, had this method and it still has them to this day and then, of course, there was the office of the Commissioner of Mental Retardation.

The next, of course, was that they had $21 million — $21 million for the one and only purpose, not competing with any objective, of placing persons from Pennhurst — it was, of course, earmarked for Pennhurst as a result of this 1970 legislation.

The third one was another rather singular achievement of Pennsylvania, and that was the Phase I report written by Dr. McDowell. This is a very carefully-detailed report proposing ten prototypes of various community residences of various types for the more dependent, the less dependent, and so on, of which a prototype was not useful for Pennhurst because that could have been utilized for others in the State.

He had worked out, as part of his report, a system of dispersal across the five counties serving
[7-86] Pennhurst. He had worked out in detail the very difficult problem of supportive services such as vocational services, day services, and so on, once the people are placed in the community.

He had costed it out and, remarkably, for once he didn't say there was enough money, but he costed all of this out as costing $17 million of the $21 million.

He had detailed implementation steps and, as I say, it was really a unique achievement because it was a blueprint. It wasn't just a vision of somebody; it was a very detailed cookbook as to how to proceed; and no other state has this.

Q. And by what date was that blueprint, as you put it, completed?

A. Oh, that was 1971. The money was allocated — 256 was in 1970 and his report was submitted in 1971, it was printed.

MR. GILHOOL: Your Honor, that report appears at PARC Exhibit Number 24.

BY MR. GILHOOL:

Q. Dr. Dybwad, today, in 1977, has it happened? Have services in the community been provided? Has Pennhurst been displaced or obviated?

A. Well, Pennhurst still has more than 1,200 people. Only twenty residents of Pennhurst, if I am correctly informed, have really benefited from the Act 256. I think they are still residing there but they
[7-87] participate in some services under the act.

Q. And the basis of you information there is the deposition of Catherine Clark, Director of the Social Services Department at Pennhurst, and the deposition of Mel Knowlton?

A. Yes.

Q. That's a question.

A. Yes. Well, I know about this.

Now the population has decreased, of course, but 151, I think, live in CLAs, what is known as the Community Living Arrangement units, and four times as many left Pennhurst and went to other institutions — 342 to Embreeville, which was a made-over facility for the mentally-ill; 96 to Woodhaven; 31 to other State schools and 112 to Pine Hill Central, which is sort of a traditional nursing home in Philadelphia.

I had something to do with it. At hearings I visited the place and it is just a nursing home.

So that four times as many went to these places and essentially they went from one frying pan into another frying pan and the fact that the second

frying pan had Teflon lining didn't particularly make it easier for the person being fried.

It was just from one system to the other so the answer is obvious — the twenty-one million and the plan which offered a tremendous promise has not been fulfilled.

Q. Why, in your opinion, has it not happened?
[7-88] Why, despite the Phase I report and the other matters that you spoke of, have community services still not been provided so as to displace Pennhurst?

A. Well, the people who are involved in public life — they say "Why?"

Questions are often very, very important. We get good legislation. Why is it not being realized?

We have money allocated; why isn't it realized?

In 1969 the President's Committee on Mental Retardation published a report entitled "Changing Panels of Residential Care" and in a concluding chapter I addressed myself to this "why" — what are the obstacles to change — and I think they fit the situation, if I may recite them.

The first is the bureaucratic inertia. Bureaucracy doesn't have a habit of moving and very often what you are getting is really a bureaucratic subversion of a declared public policy.

The State of Pennsylvania, both through the Governor, through the Legislature, declared the policy but the bureaucracy failed to carry it through and in this particular case it is so different because the money was there; that was not the excuse.

The second one is that even if bureaucrats want to move you have what the sociologists call system maintenance. It is just the momentum of
[7-89] the current service pattern that just goes on and on and it is very hard to cut in with something new because the old one rolls along and everybody is geared to this.

The third point is a very serious one, and that is, of course, the staff's concern with job status, job security, and job opportunities. It is a very well-founded concern, but nothing new.

We have in many areas in public life and in industry had to find new jobs for people and apply to the government for funds for this and a planning pattern for this, but nothing was done about this.

I think another point is in our field the insufficient regard for the very clear fact that persons with mental retardation have a capacity to make it in the community. There is still a lack of belief in this and, obviously, public officials lacking such an attitude will not be motivated to proceed. They will continue traditional prejudice, will not exert themselves, and they lay.

I really can't find other answers because you have this very strange situation of these veritable circumstances. I, as a former state official, envied Pennsylvania in the early 1970s. I still don't quite know whatever made the legislature so generous as to allocate $21 million, but they did, so it is very hard to think well now, if I want to be a little more
[7-90] specific about this last query of yours, because a program as ambitious as that, that was laid out in 1970-71 and '72, needs a manager.

You see, it involves quite a number of levels of government, quite a number of departments. It dealt with quite different things that would involve zoning ordinances, fire-safety regulations and so on.

There should have been a manager, a coordinator. You always talk about quarterbacks. I don't know what it is, but something like this was needed and from very frustrating meetings, and I still have in my files piles and piles of memoranda, it was very clear that there was no one with the primary responsibility to build up a program, to make sure that it be carried out.

Instead of that ability being just diffused, it was confused. You just couldn't pinpoint things, so between the county officers and the Base Service Units and the regional offices, which in those days were as yet getting organized, and which had as yet a questionable role, the Deputy Secretary for Mental Retardation, who presumably only had a staff function, the Deputy Secretary who carried all the field functions, the secretary herself, the state fiscal office, and the various administrative officers had their concerns — their just was no cohesion.

Let me give you an example. I remember Base Service Units were given the task to propose for
[7-91] each resident of Pennhurst a life-management plan. It was a very sound idea. After all, these people belonged someplace, they didn't belong to Pennhurst, so the Base Service Unit offered this plan to be sure that when they were ready to come back, when they were coming back, there was somebody who knew about this.

Well, they didn't do it, but whose job was it to enforce it? Who, really — through what channels should this have been pursued?

When, in Act 256, service facilities were open but they failed to assign places to Pennhurst residents, whose responsibility is it?

I mean this was the situation. I spoke of the first phase plan, which was very detailed, a marvelous document; but, of course, it was not yet translated into administrative steps, obviously not.

The person who wrote this report was an outsider, so whose problem really was it to make sure that this was translated and scheduled and deadlines and closeouts and allocations and so on; and whose job was it to really tackle it?

Obviously, it wouldn't just be Pennhurst; it would happen in other institutions. There was the problem of job security to assure the unions and

their membership you will not be foresaken, somebody is going to look after you. You serve the public, you have a right.

[7-92] None of that was done. I think here are some examples of what caused the problem.

Q. Did the officials with whom you worked in 1969 through 1971 know that these steps, these things you have mentioned, had to be done if community services for Pennhurst residents were to be a reality?

A. Oh, goodness, yes, of course.

In many cases, you see, I made reference to one memorandum earlier today of Commissioner Goldman. It just was in my mind because it was written with such unusual clarity and useful to this day by pointing out the need for monitoring and so on.

No, there were memoranda, both from within the administration and, of course, from PARC, from the Pennsylvania Association for Retarded Citizens, in which these things were spelled out and, as I said, we attended meetings in the Governor's office, in the Secretary's office, where I think, yes, the knowledge was there.

Q. Finally, did the State and county institutional officials have, as early as 1969 through 1971, the early seventies, the funds to do it?

A. Well, as of 1970 I address my question because 256, again, I say, was unusual because it was not the kind of appropriation we get in Massachusetts, where, with great public fanfare we are promised $6

[7-93] million and by the end of the fiscal year the funding has been used for something totally different, you see.

This was set aside. This was a fund, it was not an annual appropriation; so, yes, the funds were available, certainly.

In addition you, of course, had the base allocations, you had the institutional budget which you can't disregard, which also could have been utilized for this, and you had the plan, I would think, so that the answer to that would be yes.

* * *

CROSS EXAMINATION

* * *

BY MR. WATKINS:

Q. Dr. Dybwad, do you know whether those funds still exist or have they lapsed in your view?

A. No, these funds still exist, I think. I am not a Pennsylvania citizen.

I think I heard that something like $15 million is still in that account, but to the best of my knowledge these funds still exist, they continue to be earmarked.

Q. How many institutions do you have in Massa-
[7-94] chusetts of the Pennhurst nature, if any?

A. Oh, as far as I am concerned, I would put all five in the same category, even though each individual superintendent would feel that he had done something this or that that would raise him a notch above it.

I think in all fairness that they compare with Pennhurst.

* * *

BY MR. SACHS:

Q. The last question that was presented to you on direct was talking about the funds of $21 million.

Did the State and county have the funds to do it; and your answer was yes, the funds were still available?

A. Yes.

Q. To your knowledge, do you know if Philadelphia County or the other four counties in this southeastern region got any of the funds at all?
A. No. All I know is —
Q. No, you don't know, or no, they didn't get the funds?
[7-95] A. I don't know because, you see, I, for instance, would not know the procedure under which these funds would be disbursed because the question of getting funds, you see — $21 million was set aside. Philadelphia has several base units, you see. Now it would have access to this money that was allocated from the State legislature, but, obviously, I don't know through what channels the Base Service Units in Philadelphia would have to go to get the money. That I just don't know, I'm sorry.
Q. On cross examination by Mr. Watkins he asked you if you knew if these funds still existed and you said something to the effect — I heard $15 million still existed.

So, therefore, to the best of your knowledge, something in the neighborhood of six million has been spent and fifteen million are still around somewhere?
A. To the best of the knowledge of a person who is vitally interested in Pennsylvania, because I am from Massachusetts, to my limited knowledge, yes. To the best of my knowledge some of that money is still available and my recollection is that it is $15 million. I am sure that was the figure.
Q. One last question I would like to ask you:

Do you know if Philadelphia County or the other four counties would be able to start up a program to carry out the community living arrangements with their own financial resources or do you believe they would have to depend upon the State to implement this type of program?

[7-96] Can they do it on their own without State aid?
A. Well, you are speaking now not of the 256 funds.
Q. No, I am talking about any kind of State money including the 256 funds. I am asking your opinion.
A. Yes.
Q. Can any one of the five counties start up and implement or make the necessary arrangements without State aid?
A. The legislature didn't seem to think so or else they wouldn't have made the State appropriation.

* * *

REDIRECT EXAMINATION

By MR. GILHOOL:
Q. Dr. Dybwad, have you had occasion to read PARC Exhibit Number 60, a report dated in the fall of 1976, a status report as of that date of the Act 256 project?
A. I have seen it once. I am afraid you will have to refresh my memory, Counsel.
[7-97] Q. I show you a copy of PARC Exhibit 60.
A. Yes.
Q. That report shows, does it not, the continuing availability of those Act 256 funds as you have testified?
A. Yes.
Q. Have you had occasion, Dr. Dybwad, recently to read PARC Exhibit Number 58?
A. It says sixteen million and not fifteen.
Q. Yes.
A. I am sorry.

BY THE COURT:
Q. Did you say sixteen million or fifteen million?
A. Now wait a minute. No. Wait a minute, this is DES funds, I am sorry.

BY MR. GILHOOL:

Q. Exactly, but the name of this project has been called in recent years DES instead of 256. It is the same act.

MR. WATKINS: Are you referring to that?

MR. GILHOOL: I think we will stipulate to that.

MR. WATKINS: I will stipulate that the funds are still available.

MR. GILHOOL: Exactly.

BY MR. GILHOOL:

Q. With respect to PARC Exhibit 58?

[7-98] A. Yes, this was —

THE COURT: It was stipulated to how much?

MR. WATKINS: I am not certain. It is somewhere in the neighborhood of fifteen to eighteen million, I believe. I am not certain.

MR. GILHOOL: The report in the exhibit will show the figure precisely.

MR. WATKINS: Yes. We have the same report.

BY MR. GILHOOL:

Q. With respect to PARC Exhibit 58 —

A. 58? Yes?

Q. — which is entitled "CARRYOVER, COUNTY MH-MR PROGRAM FISCAL 75-76," have you had an opportunity to review and read that report, PARC Exhibit 58?

A. Well, it shows region by region for the State that there are carryovers, which I interpret to mean unexpended funds.

Q. And it shows for the fiscal years '72 through '75 some $5,600,000 allocated to the five-county region?

A. Yes.

Q. For community services which are unspent and returned to the State; is that correct?

A. Yes, county by county, right.

* * *

Testimony of J. C. Hirst

[7-101]BY MR. PEABODY:

Q. Dr. Hirst, where are you employed?

A. Pennhurst Center, Spring City, Pennsylvania.

Q. And what is your position at Pennhurst?

A. I am the Director of Psychological Services.

Q. And how long have you held that position?

A. Since 1965.

Q. Could you outline for us, if you had prior employment at Pennhurst, the various positions that you have held throughout the years?

A. Going back, I was with the State Civil Service Commission, and as the acting director of such instruction, I was associate professor at Ursinus College, Collegeville, Pennsylvania. That was my terminal position.

I worked in industry as an electrician's helper, I worked for the Penn-Central Railroad in various laboring jobs, I worked at Purdue University as a direct teaching research assistant, and I worked for the Pennsylvania State University for nine years as a continuing education instructor.

Those were my major occupations and there were other short terms in between.

Q. Could you outline the positions that you held at Pennhurst prior to becoming chief psychologist?

[7-102] A. I came to Pennhurst full time in 1958 as what they call the ward or cottage psychiatrist. This is a general clinical assignment.

Two or three months after — in those days I was designated the Chief of Vocational Services, which at that time was in the Department of Psychology, and provided the vocational service for the institution, utilizing our resident help and training them.

After that I became the Assistant Director of the Psychology Department for a number of years

and finally there was a vacancy in 1965 and I was promoted as the director and remained there and am still.

Q. So you have worked at Pennhurst for about nineteen years?

A. Close to nineteen years.

Q. Could you outline for us your education, beginning with college?

A. I attended Franklin and Marshall College in Lancaster, Pennsylvania, and graduated with a Bachelor of Science degree;

Purdue University, which is at Lafayette, Indiana, a Masters degree in Clinical Psychology; and

Temple University, Philadelphia, in 1955, with a Ph.D.

Q. Ph.D. in Psychology?

A. Yes, sir.

Q. What are your present duties at Pennhurst?

[7-103] A. I am the Director of Psychological Services and operate that department, with general management and supervision of meetings in terms of psych service.

I am also the institution's first chief consultant to the [Human Rights] Committee.

Q. Do you supervise the various psychologists on your staff?

A. I do, both directly and more desirably by having middle line supervisors.

* * *

[7-106] Q. Are there presently residents at Pennhurst which are not receiving psychological services which they are in need of?

A. In my opinion there are many residents not receiving psychological services that they need urgently.

Q. And when you say "many", how many are you referring to?
A. I would say hundreds.
Q. Hundreds?
A. Yes, sir.
Q. And when you say that they are in need of the services urgently —
A. I said urgently, yes, sir.
Q. — what did you mean by "urgently"?
A. Because time moves by. Many of these residents have been there a long time. Many of them are engaged in a struggle coping with the environment, coping with their plight; and psychological service, to be valuable, most often has to be very direct and closely interfaced with the client, one-to-one most desirable, and it is just impossible to provide that
[7-107] type of thing for all of these people that live practically under one roof. It is impossible to do it.
Q. What are the consequences for the residents at Pennhurst who are not receiving psychological services which they urgently need?
A. I think it presents a deprivation, a crippling situation, although I would mention that many of these that aren't being seen by psychologists are probably receiving other services from other disciplines, but even so —

* * *

[7-116]BY MR. PEABODY:
Q. From your observations, Dr. Hirst, have you seen residents regress or lose skills?
[7-117] A. In my opinion, I have seen residents lose skills to a degree.
Q. From your observations then and your experience in dealing with such persons, what are the major reasons for this regression or loss of skills?
A. I think there are a number of reasons. Chief

among the ones that I dwell on when I see this happen, first is what I call the motivational reason. Many of these people have been there so long that they have given up hope; and if you give up hope and drive and motivation to do different things and to go different places or to take on a different image, as the hope dwindles so does the energy.

Then there is just a sort of a quietness that overcomes a person and they'd rather not attend the workshop, they'd rather not have the counsellor talk to them about outside placement, but would want to stay at Pennhurst.

And by regression, too, as they regress, as they stop their motivation and their activity level, you see a diminution of skills.

Q. From your observations and your experience in dealing with such residents do you know of reasons why the residents have lost motivation and have become filled with quiescence, as you put it?

A. There are probably many reasons there too, but
[7-118] paramount among the one that I focus on is the nature of the environment, the environment contribution to despondency.

Q. Could you describe for us what it is about the nature of the environment which leads to this despondency, as you put it?

A. Well, my opinion is that the environment is deprived, and by "deprived" I mean it is isolate. Even though it is right next door to a community it is still Pennhurst. It has a wide perimeter of grounds around it and it is a segregated facility.

Only retarded people reside there and a few staff do reside on the grounds, and then some fifteen hundred people come in to work. That's the extent of your integration and the people who come in to work are teachers and trainers and that kind of thing, but very few peers come in.

Another thing about the environment is the physical design of the place. Many of the buildings are two stories high. People are living upstairs, some of them very fragile physically, and many of them kept up there for years and they reach a point where they'd rather not go downstairs.

Then there is the sociological part of the physical design — thirty to forty to fifty people on a cottage. That's too big a family constellation for a person to operate in to be personalized at all or to have personal relationships with the parent figure.

Furthermore, the environment, in my opinion taken from observations, does promote a crippling
[7-119] effect on behavior, education, and attitude.

Q. Are there specific things that you have in mind about the environment, things you have observed which contribute specifically to these conditions you described?

A. Yes. The physical design of some of the cottages and wards. They are so designed that they create blind spots and it is difficult for the aides to supervise these large numbers of people.

Secondly, many of the residents in the cottages are confined for long periods of time, and we all know what confinement does to a human being. It breeds aggression, and aggressions result in acting out, and acting out is contagious. People hit one another and when a person gets hit he hits back.

Then you have this long series of what we call accidents, which in my opinion are not really accidents. They are constants of the environment, the battle of a person fighting back, and I think most of them are products of the environment rather than any particular disability.

Q. The environment then is causing the aggressive behavior?

A. Right.

Q. And accidents of various kinds?
A. I believe that to a large extent.
MR. GOLDBERG: Objection, your Honor. I be-
[7-120] lieve he is now in the realm of opinion testimony.

BY MR. PEABODY:
Q. In your work, Dr. Hirst, have you become acquainted with the principle of normalization?
A. Yes, I have.
Q. And have you become an adherent of that principle?
A. I adhere to that policy or principle or ideal. I believe it works.
Q. Can you describe for us what it means to you?
A. Normalization in terms of handicapped people simply means to me that if you desire to have a handicapped person develop and reach the point of, say, the average of society, then you must give him experiences and environment and opportunity such as the average person in the society that we are having him meet, their base line.

So in a nutshell a normalization means to become normal you must have a normal experience in life environmentally, familywise, culturally, educationally. You must at least have the opportunity.

It is unfair to expect handicapped people to achieve what we did when we did not give them the opportunity to be counseled like we have.
Q. From your observations and your experience at Pennhurst can the environment at Pennhurst presently provide a place to implement these principles?

* * *

[7-124] BY MR. PEABODY:
Q. Dr. Hirst, what observations have you made at Pennhurst regarding the possibility of implementing the normalization principle which you have described for us?

A. I observe an environment that is not conducive to normalization.
Q. And what have you observed that is not conducive, specifically?
A. Because the environment is untypical of our society. It segregated, it is isolate, it is group living versus family living.
Q. And by group living what do you mean?
A. People living together in very close physical and psychological contact in large wards, sleeping dormitory style, incarceration and inhumane confinement in that building.
[8-109] Q. You used the word "incarceration" with reference to that building.

Is the situation there worse than for other buildings?
A. I think the New Horizons building is the worst area in the institution.
Q. I believe I recall Gunnar Dybwad talking about it.

What's the nature of the worst building? I thought it was one of the newer buildings.
A. It is a new and very expensive, architecturally-clean building, safe and bombproof; but, as Dr. Dybwad pointed out, better than I can, it is no place for habitation, for people to live. There are blind spots in the ward. It is a high-rise building with elevators and the only steps inside being fire exits.
Q. Are there people who are incarcerated there without the opportunity for outside recreation?
A. Absolutely.
Q. What proportion?
A. I won't say that nobody goes out.
Q. What proportion of people, based on your observation, get to have daily recreation outside?
A. Out of the six wards, I would say one or two at the most, and for a very limited time.

[8-110] Q. One or two wards or one or two people?
A. During weather like we are having now, one or two wards, maybe after supper or out for a period in the morning; but it is even difficult there because the play areas, the recreation areas, are benches. There are some benches there and some swings and sliding-boards.

But you must remember we have adults in that building who might want to be beyond the sliding-board age and the seesaw.
Q. No recreational facilities for the adults in the building?
A. There is a swimming pool in the basement and there is a gymnasium.
Q. Nothing else?
A. Well, the two playgrounds, you know, which I regard as simply large cages. There are no trees. There is not a water fountain, there is not a toilet.

It is very inconvenient to take them there and I have compassion for the aides who try to do that.
Q. So the aides would be deterred from doing that because of the difficulties?
A. The realities of the difficulties; right.
Q. Have you contacted any official higher than Dr. Youngberg regarding your complaints?
A. I have talked to several high-ranking State officials in the last few years.

[8-111] Q. Who are they?
A. Going back quite a bit, even before Dr. Youngberg and Dr. Smilovitz came on the scene with us and before New Horizons opened, I talked with Dr. Donald Jolley, who was the Commissioner of Mental Retardation for the Commonwealth.
Q. How about since Dr. Youngberg?
A. I have talked with Mrs. Irene Pernsley, who is the ex-Deputy Secretary of Welfare for Region I here in Philadelphia about my concern for the plight

of the residents at Pennhurst and the condition of the institution.

Mrs. Pernsley generously granted me three and a half hours to chat with her.

Q. Do you know if she communicated any of those concerns to Helene Wohlgemuth, Secretary of Welfare?

A. I don't know. I certainly hope she did.

Q. Did you ever speak to Helene Wohlgemuth about that?

A. I did.

Q. And that was briefly at Pennhurst?

A. I spoke with her briefly at Pennhurst when she visited the modular community, and I —

Q. Did you ever speak with Mr. Beal, Frank Beal, about it?

A. I never spoke with Mr. Beal. I have written letters on behalf of advocacy groups and myself to Mr. Beal.

Q. And has he responded?

A. I never saw the answers come back from him.

[8-112] They came back from subordinates of Mr. Beal.

Q. Do you know if Mr. Beal has visited Pennhurst?

A. He has visited Pennhurst, I think, on one or two occasions, but I have never seen him.

Q. Any other officials?

A. Mr. Stanley Myers. He addressed one evening a "Plans for Pennhurst" meeting and Mrs. Valaida Walker, who was his deputy, I think, for the region. I spoke to both of them and addressed them asking them if they recognized the emergency that we had at Pennhurst.

Q. What did they say?

A. Yes, we do.

Q. Why do you consider it an emergency?

A. I consider it an emergency because of, you know, the whole battery of things that we have all

been testifying to. The residents at Pennhurst have a plight that must be advocated because they are in the situation.

We try to get them to improve, to get them in the modular homes to give them a place to live before they go to the community, to give the community time for a group of homes; and then the Commonwealth turned down the plan for Pennhurst and the net result is that the residents wind up in the substandard areas of changing environment, which is worse than they end up with in some ways.

[8-113] Q. Dr. Hirst, based on your experience in attempting to change Pennhurst and meet the plight of its residents, are you satisfied with the progress the Department of Public Welfare has made in, let's say, the past few years? Are you satisfied that that progress will result in what will be best for the resident?

A. I won't say that there have not been sincere efforts and I will not say that there have not been sincere efforts and concern coming out of the Department of Public Welfare.

I am cognizant that the system moves slowly, but I really believe that the plight of the residents at Pennhurst cannot be moved by the present actions of the system I have observed, unless in concert with those actions there as an individual and group advocacy for each resident that is unfortunate enough to have to be at Pennhurst.

* * *

[8-114] A. I couldn't get Freddie or participate in the admission of any retarded son at Pennhurst Center for the simple reason, not that there aren't kind people there that would try to help him and love him; but because his destiny, if he were admitted to Pennhurst his destiny would not be defined to me

and Mrs. Hirst as to where he might be thirty days from now or thirty years from now.

Under the present plan he could be in Pennhurst until the year 2000.

Q. How would you characterize his destiny at Pennhurst?

A. With the present dilemma in terms of programming and life management and what the agencies are going to do and how they are going to get together to reshape and resolve the plight of Pennhurst residents, I am sorry and regret it because I am part of Pennhurst.

I regret to have to say that I think his life, his lifeline and his time-line would be haphazard.

* * *

[8-119]BY MR. WATKINS:

Q. Doctor, are you aware of any residents who have had beneficial programs terminated for reasons of punishment; and you can define "punishment" before you answer the question.

A. Punishment, as we use it in the profession and in our operational work usually means the withholding of some pleasant thing or a reward as a result of an activity or the lack of activity on the part of the person. That's punishment.

If you are not good you won't go to the movies. That's the removal of a pleasant thing.

I think what I said, and I am willing to stand up for everything I said, but recollecting back I said that I was against the deferment or the denial of programs for atypical behaviors and that I thought that kind of thing was punitive on the part of the institutional system that imposed that on a person. I think if you punish people for a reason like that, that isn't the resident's fault, you deprive him of a full range of programs because of behavior that isn't just right.

[8-120] Q. Let me ask you —

A. You know, as far as getting a list of case numbers, I am willing to cooperate with the Court but I can make it a lot easier than that and go on record as saying many of the residents of the New Horizons Building I place in this class; in fact, most of them.

Q. All right.

Most of the residents in the New Horizons Building, in your opinion — I just want to make sure we are talking about the same thing — have had therapeutic programs deferred or terminated —

A. I won't say that; I will say not initiated.

Q. All right.

A. Because of the demand.

Q. I am well aware of that.

MR. FERLEGER: May the question be answered, please?

THE COURT: Go ahead, Doctor. You may finish.

THE WITNESS: Because the demand — you know, the word is interesting and we are both guilty, I guess. Deferment, withholding, and not finishing, you know, to me are all three equal.

BY MR. WATKINS:

Q. I am asking you about deferring and withholding.

A. I think a lot of the programs for New Horizons
[8-121] residents have been denied, deferred, withheld because of the nature of their hyperactive, atypical behaviors, much of which is consequent to the residence they live in.

That is a conviction I have and I am not saying whether I know all the answers on it, but that's a conviction I have.

Q. When was the last time you reviewed the annual program reviews for the residents of the New Horizons Building?
A. I have not reviewed those.
Q. When was the last time you got an assignment or an inventory of the programs that are being offered to the residents of the New Horizons Building?
A. I get a picture of that about every day, Mr. Watkins. I have two psychologists working upstairs.

I get the psychs, I get the treatment plans, I have verbal conversations with those people and I am up there on those frequent occasions. It is right upstairs.

There are visitors that come in the New Horizons Building that want to see this new building.

I can tell you what the programs are up there. They are self-help programs. They are very limited programs that have been going on for years.

The outreach programs from that building are very lean and far between, and small group activity, other than the foster grandparents who can only take a handful at a time because of the fragile nature of these residents.

* * *

[8-122] Other than that I don't believe any of them have a comprehensive program.

* * *

Q. Do you know of any residents in the New Horizons Building or anyone that had a beneficial program that was at a time existing and has had that program terminated as a means of punishment and

* * *

[8-123] A. I said there is no individual at Pennhurst that I know that is punishing anyone purposely, maliciously, even designing punishment.

But there are conditions and circumstances for which we are all responsible that I feel are punitive, punitive to the class of residents at Pennhurst.

* * *

* * *

[8-4]

Testimony of Robert Troester

* * *

BY MR. STUTMAN:

Q. Mr. Troester, did you ever live at Pennhurst?

A. Yes, I did.

* * *

[8-11] MR. STUTMAN: May I approach the witness, your Honor?

THE COURT: You may.

(Wrist restraint was marked PARC Exhibit 73 for identification)

BY MR. STUTMAN:

Q. I am holding up what has been marked PARC Exhibit 73. Have you ever seen this before?

A. Yes, I did.

Q. Have you ever seen an object like this that was bigger than this?

A. Yes, sir.

Q. What is this, Mr. Troester?

A. It is something like a straitjacket.

Q. Do you know what it was used for?

A. They used to put it around the boys, over their necks. Sometimes they would tie them behind their backs.

Q. Would they be standing up or sitting down?

A. Sitting down.

Q. Have you ever seen anyone in something like this —

A. I did.

Q. — when you were at Pennhurst?

A. Yes, sir.

[8-12] Q. Did you ever seen anyone in a larger one of these?

A. Yes, sir.
Q. Why do you think people were put in those?
A. They was bad.
Q. Do you know what a seclusion room is?
A. I do.
Q. What is it?
A. It is to put boys in.
Q. Where do you live now?
A. Doylestown.
Q. When did you move there?
A. Two weeks — I think it was two weeks ago, on my mother's birthday, I got out, out of school.
Q. Would it be a couple of years ago that you moved there?
A. Yes, sir.
Q. And did you ever want to leave Pennhurst?
A. Yes, sir.
Q. Did you want to leave Pennhurst for a long time?
A. Yes, sir.
Q. Did you tell anybody there that you wanted to leave?
A. Yes, sir, I did.
Q. What happened?
A. They told me to wait a while.
Q. And did they tell you why you had to wait?
A. No, sir.
[8-13] Q. One day they said you could go?
A. Yes, sir.
Q. And was that day your mother's birthday?
A. Yes, sir.
Q. In Doylestown do you live in a home?
A. Yes, sir.
Q. How many other men live there with you?
A. Seven men.
Q. Is there any staff?
A. Maxine, Walt — more staff is there, working there now.

Q. Maxine and Walter are there all the time?
A. Yes, sir.
Q. And other staff come when Maxine and Walt have days off?
A. Yes, sir.
Q. Does the door to that house have a lock? Is there a lock on the door?
A. Yes, sir.
Q. Do you have a key to that lock?
A. Yes, sir, I do have a key.
Q. When you come in the front door what does the house look like? Is there a living room?
A. A living room.
Q. What other rooms are there?
A. A dormitory.
Q. Are they upstairs?
A. Yes, sir.
Q. And that's where the men sleep?
[8-14] A. Yes, sir.
Q. Now you said dormitory. Is it like the dormitory at Pennhurst?
A. No, sir.
Q. How is it different?
A. I mean it is better.
Q. I'm sorry. Go ahead.
A. It is better there.
Q. Are there separate rooms?
A. Separate rooms.
Q. How many men sleep in the room where you sleep?
A. Just by myself, sir.
Q. You have your own room?
A. Yes, sir.
Q. Do you have a bureau where you can store your personal belongings?
A. Yes, sir.
Q. Is there a closet where you can put your clothes?
A. Yes, sir.

Q. Is there a bathroom there?
A. Yes, sir.
Q. How many showers are in the bathroom?
A. One.
[8-15] Q. Is there a shower curtain?
A. There is a shower curtain.
Q. When you go in the bathroom in the morning are other men in there with you?
A. No, sir.
Q. Do you have privacy in the bathroom?
A. Yes, sir.
Q. When you are in the house and the other men are there and you want to be alone, where do you go?
A. Upstairs.
Q. To your room?
A. Yes, sir.
Q. Who does the cooking in the home?
A. The boys do it; sometimes Maxine helps us out. She is a big help.
Q. Do you cook sometimes?
A. Yes, I do.
Q. Where did you learn to cook?
A. Food, and she helps me. Maxine helps me out, she gives a hand.
Q. And who cleans up?
A. The boys do, but I am trying — they don't let me clean up. I just wash dishes for the weekend.
Q. Who shops for the food?
A. Maxine does; we help her out.
[8-16] Q. Do you go to the local supermarket in Doylestown and buy food together?
A. Yes, sir.
Q. Is the food good?
A. Yes, sir.
Q. Where do you work? Do you work?
A. Yes, I work.
Q. Where do you work?

A. Doylestown some time. Now I am working in Ivyland.
Q. In Ivyland?
A. Yes, sir.
Q. Is that the workshop?
A. Yes, sir.
Q. How do you get from Doylestown, your home, to Ivyland?
A. By bus.
Q. That workshop that's in Ivyland is a new one, isn't it?
A. Yes, sir.
Q. Wasn't there the old one in Doylestown?
A. No, sir.
Q. Do you like the Ivyland workshop?
A. No, sir; too far from the house.
Q. Would you rather be able to walk to work?
A. Yes, sir.
Q. Did you used to be able to walk to work?
A. Yes.
[8-17] Q. And then they moved the workshop?
A. They moved it up in Ivyland.
Q. Strike that.
A. That's all right.
Q. What is your job in Ivyland at the workshop? What do you do there?
A. I usually do collating.
Q. Collating?
A. Yes, sir.
Q. And do you get paid for that work?
A. Yes, sir.
Q. How much do you get paid, do you remember? How much do you get paid?
A. Five dollars, sometimes more.
Q. It is different one week from the next?
A. Yes, sir.
Q. And where do you spend that money?
A. In the stores.

Q. In Doylestown?
A. Yes, sir.
Q. Do you go to the movies?
A. I didn't hear you.
Q. Do you go to the movies?
A. Yes, sir.
Q. In Doylestown?
[8-18] A. (There was no response.)
Q. Do you go to restaurants?
A. Yes, sir.
Q. Do you and the other men go to restaurants and to the movies when you want to?
A. I go by myself. I like to be alone sometimes.
Q. Do you work on Saturday and Sunday?
A. No, sir.
Q. What do you do on a Saturday and Sunday in Doylestown?
A. Well, I get up — I stay in bed on Saturday. On Saturday mornings I clean, clean the house out.
We all pitch in and help to clean the place up.
Q. Did you clean up in Pennhurst when you were there?
A. We never did, sir.
Q. Were there other people to do that?
A. No, never did.
Q. Do you like your home in Doylestown?
A. Yes, sir.
Q. Would you like to live there for a long, long time?
A. No, sir.
Q. Where would you like to live?
A. Apartment.
Q. In an apartment?
A. Yes, sir.
Q. With fewer people?
A. Fewer people.

* * *

CROSS EXAMINATION

[8-19] BY MR. FERLEGER:

Q. Hi. My name is David Ferleger. I am a lawyer for some of the people in this case.

How old are you?

A. Nineteen.

Q. How old?

A. Going on nineteen.

Q. And do you know how to read?

A. Not so good.

Q. What kind of things do you read?

A. I don't read sometimes.

Q. Did you like living in Pennhurst?

A. No, sir.

Q. Will you tell me why?

A. There's too many fights, too many arguments, too many stealings going on and all that, robberies, undesired things, and I'd change around.

I used to do bad things too, but now I changed myself. I am a different kind of man now.

* * *

[8-22] **Testimony of R. Hill**

MR. LASKI: Your Honor, the Pennsylvania Association for Retarded Citizens calls Mr. Robert Hill.

ROBERT HILL, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. LASKI:

Q. Mr. Hill, where do you live?

A. 336 North Street, Chester.

Q. Did you live at Pennhurst?

A. Yes.

Q. What date did you leave Pennhurst?

A. April 15, 1971.

Q. In what building did you live when you were at Pennhurst?

A. L-3.

Q. Did other men live in the building?

A. Yes. It was more men than that.

Q. Was there more than one floor in L building?

A. They'd use the bottom of the canteen and there was a second L-2, and I was on the third floor.

Q. Do you remember what L-2 was like?

A. It was like one big room with forty in them.

Q. Did you work at Pennhurst?

A. Yes, I worked at Pennhurst.

Q. What was your job?

[8-23] A. In the greenhouse.

Q. Tell me about your job.

A. I would take care of the flowers, and run the flower beds and bring in dirt and fill up the flower pots and things like that.

Q. Was it pretty hard work?

A. No, not for me.

Q. Did you work every day?

A. Except Sundays up there at the greenhouse.

Saturday and Sunday I didn't work at the greenhouse.

Q. Did you do other jobs at Pennhurst?

A. I quit around three and take a shower and take a little walk until supper time. After I eat I go up to the blind to help them out.

Q. What kind of things did you do for the blind?

A. I'd wash the dishes up there, scrub the walls and the like, give them a shower, something like that, and take down the dirty laundry for them.

Q. This was after you finished work at the greenhouse?

A. Yes, after I come back and take a shower and eat supper I worked.

Q. Did you get paid any money for your work at the greenhouse?

A. No, I didn't get nothing.

Q. Did you get paid any money for working on the blind ward?

A. Oh, yes. The attendants would give me a couple
[8-24] of dollars for doing the work.

Q. They would give you a couple of dollars for working on the blind ward?

A. Yes.

Q. Did the staff give you medicine when you were at Pennhurst?

A. Yes, they give me medicine.

Q. Do you know for what reason they gave you medicine?

A. I have Parkin's disease, what they say, Parkin's disease.

Q. Do you take medicine now?

A. No, I don't take it no more.

Q. Have you been to the doctor since you left Pennhurst?

A. Yes, I have been to Crozer Hospital, the doctors.

Q. Did the doctor tell you whether you had Parkin's disease?

A. No, they didn't find it. No, they couldn't find nothing.

* * *

BY MR. LASKI:

Q. Tell me about the food and meals at Pennhurst:

A. Oh, the oatmeal would be kind of cold with a little sugar in it. Then we had toast and tea or something and toast, but some time I wouldn't eat it half the time in the morning, I wouldn't.

Q. Were you the only one who didn't eat it?

[8-25] A. Oh, I wasn't the only one.

Q. Did some other men —

A. There were some men that wouldn't eat half the food, they wouldn't.

Q. What did you do to keep from going hungry during the day?

A. Oh, in the morning, they had toast, it was just cereal or something else they had; but for lunch the food would be bad and I'd go down to the canteen for something.

Q. And you would spend your own money to eat at the canteen?

A. Yes. I spent my own money from the presents; I took it up there.

Q. Were the men on L-3 allowed to keep their own personal belongings, such as radios and TVs and books?

A. Well, sometimes the attendant would take it from them. As soon as you'd go down to the mess hall and come back the stuff would be gone. You see, they'd make everybody go out.

Q. Did you just tell me that sometimes the attendant would take the radios away?
A. Radios sometimes, sometimes like the clothes or something.
Q. They would take away the clothes?
A. Yes, or something the parents would give them.
Q. What would happen when they took the radios away? Did you complain?
A. Yes. I went down, I said to the girl, you can take their stuff but you don't take my stuff from me. I
[8-26] wasn't no kid you were playing with.
Q. And did sometimes the parents and the friends of the other men complain?
A. They would complain about it.
Q. And did the people get their possessions back?
A. Half we'd get them back.
Q. But they had to complain?
A. Yes. See, the parents come up there.
Q. Were the men in L building allowed to go where they wanted to and do what they wanted to do when they went walking?
A. I would take a walk down by the farm, like over in the big field, with a friend of mine.
Q. Did you have to follow the rules at Pennhurst?
A. Well, some rules, they was all right. Some rules, they would make up their own rules, you don't do this and you couldn't do that.
Q. What kind of rules?
A. Like we couldn't go down by the kitchen and wait to get in. Sometimes they will tell you you go down to the mess hall and wait until you get in, to get away from the dorm.
Q. And what would happen to the men if they did not follow the rules?
A. They'd put a conduct on them.
Q. What was that?
A. A conduct on them.

[8-27] Q. Were they sometimes punished for not following the rules?
A. Yes. They'd put them in their rooms, like that, and they would not be free to go to mess hall and they'd bring their tray over to them.
Q. How long would they have to stay in the room?
A. Oh, about two weeks. Some would stay in for five days.
Q. They stayed for five days in the same room?
A. In the room.
Q. And they weren't allowed to go out to get their own meals?
A. No.
Q. Is Pennhurst a good place to live?
A. No.
Q. That's enough about Pennhurst. Let's talk about where you live now.
A. All right.
Q. Where do you live now?
A. 336 North Street.
Q. And who do you live with?
A. Reverend Cobb.
Q. And how many people?
A. There's twelve in the house.
Q. Tell me about the house that you live in?
A. Oh, it's pretty nice. He fix up the basement for me and my brother. It's pretty nice there.
Q. Do you have your own room?
[8-28] A. There is one big room downstairs.
Q. For you and Herman?
A. Yes.
Q. Do you have your own closet and your own drawers?
A. Yes, we have our own closet.
Q. Do you have your own television?
A. Yes, I got my own TV.

Q. Do you think that's a good idea to have your own belongings and your own TV?
A. Right.
Q. Why is that?
A. If we were together there'd be a lot of fights. If you have your on TV you'd be better off.

BY THE COURT:

Q. What do you like to watch on TV?
A. I watch like Channel 29, like Clark Gable or something like that, or Power Street, something like that.

BY MR. LASKI:

Q. Does anybody tell you when you can watch it and what you have to watch?
A. No.
Q. Do you think that's good?
A. Yes, that's right.
Q. Are you working now, Mr. Hill?
A. Yep.
[8-29] Q. Where do you work?
A. Up at a deli —
Q. What is your job there?
A. I got a job going around and picking up forks, pick the pots, and taking out trash and dumping stuff on the tables for the guys that work on them.
Q. Do you work every day?
A. Five days, except holidays and Saturday and Sunday.
Q. Do you do other work for the neighbors?
A. I go around and clean up the yard for them.
Q. Do you get paid for that?
A. Yes, they pay me.
Q. What do they give you?
A. Some give me five, four, three. If it is a big yard they give me about ten dollars.
Q. So you do a lot of work around?
A. Right.

Q. What do you do when you are not working?
A. Oh, I take a walk or go fishing.
Q. Do you like to go fishing?
A. Yes, I like to go fishing.
Q. When is the last time you went fishing?
A. Last Saturday.
Q. Did you catch anything?
A. I caught one. One Saturday I caught ten.
[8-30] Q. Do you read the newspapers?
A. Yep, read them.
Q. Do you read books?
A. Books.
Q. What kind of books do you read?
A. I read like — no sex — murder stories, like that.
Q. You don't like murder stories?
A. Yes, I read them.
Q. What kind of other ones do you like?
A. Well, I look up a dictionary or something like that.
Q. Are you registered to vote?
A. Yes.
Q. When did you do that?
A. I started, I filled the papers out and I got my card. They told me I'd be ready for the next time we have an election, to vote.
Q. Do you plan to vote in the next election?
A. Right.
Q. What do you feel is better about your life now with Reverend Cobb than it was at Pennhurst?
A. I go out — you know, you can't go here, you can't go there. It's pretty nice there.
Q. And you can do what you want to do?
A. I don't stay out all night long, you know. I don't go out.
Q. Can you summarize at all why it is better to live
[8-31] in the house than it is at Pennhurst?
Q. Okay. You can't go where you want to go and you end up, they tell you what time.

Where I stay at now I can pick what time to go to bed and what time to get up. I can just do what I want; that's all.

* * *

[8-33] **Testimony of Herman Vaughn**

BY MR. LASKI:

Q. Mr. Vaughn, where do you live?

A. 336 North Street.

[8-34] Q. How old are you?

A. Thirty-six.

Q. Did you live at Pennhurst?

A. Yes, I do.

Q. How many years did you live at Pennhurst?

A. Thirteen years.

Q. In what building did you live?

A. Penn Hall 2.

Q. Tell me, what was it like at Pennhurst in Penn Hall 2? Is it a good place for people to live?

A. No, sir.

Q. Why do you think it is not a good place for people to live?

(Reporter's note: From this point on the testimony of Mr. Vaughn as follows was constructed using stenotype notes and a tape recording.)

THE WITNESS: Because they treat you mean and all that.

BY MR. LASKI:

Q. How do they treat you mean?

A. They want to slap you, slap you around.

Q. Who slaps you around?

A. The attendants.

[8-35] Q. Could you come and go as you wanted to from Penn Hall?

A. No.

Q. Could you watch TV and listen to the radio or play the stereo by yourself?

A. No, I couldn't.

Q. Were people sometimes hurt at Pennhurst?

A. No.

Q. Were they sometimes slapped around by the attendants at Pennhurst?

A. (Unintelligible.)
Q. Were people sometimes punished at Pennhurst for not following the rules?
A. Yes, sir.
Q. In what ways were they punished?
A. Like you, when you want to run away to (unintelligible).

Then you were going to places that you would go out, and at the desk, you can't — (unintelligible) —

Q. And what did you say?
A. And I said why I can't go.
Q. And do they give you a reason why you couldn't go.?
A. No.
Q. Were there times when you had to stay inside Penn Hall?
A. Yes.
Q. Could you go outside after six o'clock?
A. No, no.
[8-36] Q. Were there some times the men were punished by staying in Penn Hall for a long period of time?
A. Yes, you do.
Q. How long?
A. (Unintelligible.)
Q. Were they allowed to leave the building?
A. No.
Q. Did you work at Pennhurst, Mr. Vaughn?
A. Yes, I did.
Q. What kind of work did you do?
A. I used to take the trays to the kids in the ward, dress them and bathe them and soaping them.
Q. And did you work every day taking care of the patients?
A. Yes, come in at seven o'clock in the morning.
Q. And in what wards did you take care of the patients?
A. U-2.

Q. What were the clothes like at Pennhurst?
A. It's a green — green pair of pants and a brown shirt.
Q. Did everybody wear the same kind of clothes?
A. They do, yes.
Q. Did you get paid for your work?
A. No, I didn't.
Q. Did you sometimes take care of the patients on Saturdays and Sundays?
A. Yes, I did.
[8-37] Q. Did sometimes the patients have visitors on Sunday?
A. Yes.
Q. And did you have any jobs on Sundays?
A. No, sir, the only time is when (unintelligible) — you had a piece of paper, a slip, and take them to the ward, to the attendants, and then you dress them, and take them, down to the office.
Q. Did you ever get any money for doing that work?
A. No.
Q. Tell me what a day was like living at Pennhurst. What time did you get up?
A. I got up at around between seven o'clock in the morning and going to work at seven and I worked until one.
Q. What happened at one?
A. Then I'd go back to Penn Hall and then go down to get something down — I went down to Penn Hall, I found my clothes on the floor, my bed messed up (unintelligible) — they took all my clothes out of my closet and throw them on the floor.
Q. Had you cleaned your room in the morning?
A. Yes, I cleaned my room in the morning.
Q. In the evenings — what did you do in the evenings after work?
A. I believe all I could go up the hill to talk to my girl, and it was a cop there named Ames. I asked the

cop — (unintelligible) — and they wouldn't let me
|8-38| and I — down to him to the canteen.
Q. Are you telling me you weren't allowed to go up the hill to talk to your girl?
A. No.
Q. You didn't have permission to do that?
A. No.
Q. Did you ask for permission?
A. Yes, I asked and he told me no.
Q. Did you ever have any money at all at Pennhurst?
A. I had my aunt gave me money.
Q. And were you allowed to keep that money?
A. No, I didn't — couldn't have it.
Q. What happened to that money?
A. The 'tendant take — the superintendent, the superintendent take it off of you, but one time when I go back to ask the superintendent could I have the money, the superintendent gave the money (unintelligible) somebody else (unintelligible).
Q. You asked the superintendent whether you were allowed to have the money?
A. The money.
Q. And what happened then?
A. He gave it — (unintelligible) — to a nurse — (unintelligible).
Q. Your money was given to somebody else?
A. Yes.
|8-39| Q. And you did not get it?
A. No, I didn't get it.
Q. That's enough about Pennhurst, Mr. Vaughn.
Tell me about where you live now. What is your home like?
A. Fine.
Q. Who do you live with?
A. Reverend Cobb.
Q. Could you describe the rooms where you live?
A. It's fine. It's pretty good, yes.

Q. And do you prepare your own meals at that home?
A. (There was no response.)
Q. Do you help prepare the meals at home?
A. No, I don't.
Q. Do you help to wash the dishes at home?
A. Yes, I do.
Q. Do you help to clean up?
A. Yes.
Q. Do you have a job?
A. Yes, I do.
Q. And what is your job?
A. I wash dishes at Strawbridge & Clothier. I wash dishes.
Q. Do you have to go to work today?
A. Yes, sir.
Q. How many days a week do you work?
[8-40] A. Five day a week.
Q. And how do you get to work? How do you travel to work?
A. My dad take me in the morning, between eleven-thirty, and I take the bus to come home at nighttime.
Q. And how do you get back from work at night?
A. By the bus.
Q. Is that a long bus ride?
A. Yes, it is a long ride from Springfield to Chester, yes.
Q. How many buses do you have to take?
A. I take the 69th Street bus that goes to Chester, and I take the 76 that comes to Chester, and then that bus 76 don't come until quarter of ten.
Q. Do you get paid for the work at Strawbridge & Clothier?
A. Yes.
Q. Do you get a check every week?
A. Every Thursday.

Q. Are there any other benefits that you get from working at Strawbridge & Clothier?
A. Yes, I do.
Q. What are those?
A. Like they have parties, go to a benefit.
Q. Do you get any benefit on making purchases and buying things at Strawbridge's?
A. Yes, twenty off.
Q. And do you go shopping and what do you buy?
A. I buy records, tapes —
[8-41] Q. Do you have your own stereo?
A. Yes.
Q. Does anybody tell you when you can play your stereo?
A. No.
Q. Do you play it when you want to?
A. Yes.
Q. What do you do when you are not working on Saturdays and Sundays?
A. I go in the back yard and play my stereo.
Q. What else do you do?
A. Sometimes I go to town shopping, out to Springfield, do my shopping.
Q. Do you have to ask permission when you want to go shopping?
A. No.
Q. Do you go to church on Sunday?
A. Yes.
Q. Do you help out sometimes at church on Sunday?
A. Yes.
Q. And what do you do at church?
A. I sing, like sing, put the people down, sitting down in church.
Q. Do you work at the church?
A. Yes.
Q. Do you mean in the choir.

[8-42] A. No, not the choir; just an usher.
Q. You are an usher?
A. Yes.
Q. Is life better living in Chester than it is at Pennhurst?
A. Yes, you do.
Q. And what makes you think that it is better at Chester than it was at Pennhurst?
A. Chester is better. You have more freedom in Chester than you have in Pennhurst.
Q. You have more freedom at Chester than you had at Pennhurst?
A. Yes.
Q. Now explain to us what you mean by having more freedom.
A. In Pennhurst you cannot have no downtown at all. In Pennhurst you cannot do anything you want to do; and another thing, in Pennhurst, they ask you if you want to go to work, you can have to stay in your room at all.
Q. And you can do what you want to do in Chester?
A. You can do whatever you want to do in Chester.
Q. Do you think Pennhurst is a good place to live?
A. No.

* * *

BY MR. FERLEGER:

[8-43] Q. Do you still think about Pennhurst sometimes?

A. Yes, I do.

Q. When you think about Pennhurst sometimes what do you think about?

A. I think at Pennhurst they treat you mean.

Q. Are you ever afraid of going back to Pennhurst?

A. No, I don't want to go back there.

Q. Do you ever worry that you might have to go back?

A. No.

* * *

[8-45] **Testimony of Mrs. G. Auerbach**

DIRECT EXAMINATION

BY MR. GILHOOL:

Q. Where do you live, Mrs. Auerbach?

A. I live at Philip Murray Senior Citizens Apartments, Stenton Avenue and York Road.

Q. Please sit down.

A. Okay. Thank you.

Q. Will you tell the Court of the milestone dates in your life?

A. Do you mean when I was born?

Q. That sort of thing.

A. I was born in March 1900. I am seventy-seven years old and I was born in Russia, came to this country in October 1909, so I wasn't quite ten years old when we came to this country.

Q. And thereafter?

A. Thereafter I went to school and in 1919 I was lucky enough to get married. Then I had two boys, one in 1921 and another one in 1925.

Q. Is one of your sons retarded?

A. One of my sons is retarded, the younger one, Sidney.

Q. And how old is Sidney now?

A. Sidney is past fifty-one.

[8-46] Q. Where does Sidney live?

A. Sidney lives now in the Ashbourne Terrace Apartments, at 6060 Crescentville Road.

Q. And that's in the Lower Northeast?

A. The Lower Northeast Philadelphia.

Q. With whom does he live there?

A. He lives with two other boys in a two-bedroom apartment, completely furnished for housekeeping.

They have one bathroom for the three boys and two bedrooms — one large bedroom Sidney shares

with another boy, and the other bedroom is a smaller one and one boy lives there.

Q. And who operates that apartment at that address?

A. The Ralph Bruce Nippon Association. The Ralph Bruce Nippon Association are responsible for Sidney being taken out of Pennhurst.

Q. And how long has Sidney lived at that apartment at Ashbourne Terrace?

A. Well, when he first came out of Pennhurst they had a house at — I think it was 1410 Chelten Avenue. He lived there — he came out of Pennhurst October 1973 and they lived there, I would say, about two years, because it's three and a half years since Sidney is out and they are in Ashbourne Terrace about a year or past a year, three boys to one apartment.

Q. Does Sidney work?

[8-47] A. Sidney works at the PARC Workshop, 24th and Westmoreland.

Q. And how does he get there?

A. He gets there by taking two buses to go to work and two buses to come home.

Right now the buses are not working; they have a minibus that takes them to work.

Q. You said that Sidney left Pennhurst in October of 1973.

When did he go to Pennhurst?

A. We took Sidney to Pennhurst in March of 1935.

Q. Do you have greater peace of mind now that Sidney is living in the community than you had when he was living at Pennhurst?

A. There is no comparison, because Sidney now is living a good life. He is living a normal life and when he was at Pennhurst there was nothing to look forward to. It was hopeless. It was just — he was just a number.

Q. Do you feel more secure about Sidney's welfare now than you did when he was living at Pennhurst?
A. I most certainly do; I most certainly do.

I am getting on and I feel that when my time comes Sidney is in the right hands and will be able to take care of himself, which he is doing now.
Q. What differences do you see in Sidney now that he has left Pennhurst and is living in the community?
A. Well, as I said a moment ago, sir, the life now is a normal life. Sidney goes to work, he has a bank account, he keeps house.

[8-48] He called me last night and told me he was made in charge of the kitchen, and I want to tell you that kitchen is going to be well taken care of because one of the things that Sidney has developed is being a boss, very bossy, and he will see to it that the kitchen is going to be kept clean, immaculate.
Q. This is the apartment kitchen?
A. It is the apartment kitchen.

They have a beautiful living room with dining area. They have entertained me. Sidney has made dinner for me, for my birthday, for Easter, for his birthday, and he entertains me, as I entertain him and his friends. When I have time they come up on Sunday for brunch and now they are looking forward to resuming it as soon as the strike is over.
Q. What are some of the things that Sidney does now that he didn't do at Pennhurst in addition to the shopping and the cooking that you mentioned?
A. Well, he is leading a normal life. He gets up in the morning. He has a job. The Nippon Association provides wonderful programs for them for the weekend.

He has taken trips. Two years ago he went to Mexico. One year they went to Canada; going to Atlantic City is an everyday thing now. It is not such a big deal any more.

They have been to the United Nations, they
[8-49] went to Disneyland one summer.

And he buys his own clothes. They had a dinner at Palumbo's in December and Sidney was all dressed in a brand-new outfit and he said, "Don't you think I look like a thousand dollars?"

I said, "No, I think you look like a million dollars."

And for that he wanted to go buy me a drink.

Well, the fact that he asked me to buy him a drink, that was a big moment in my life because Sidney has — I mean there is no comparison to the way Sidney was when he was at Pennhurst.

There he was a number. He was subdued. He never talked and now you can't stop him and everything he says makes very, very good sense, very good sense, as my friends in the building have noticed.

I have lived in this building for ten years and they saw Sidney before he came out of Pennhurst when I used to bring him home for weekends and they see him now and there's just no comparison, everybody notices it. He is well-known in the building. He is the belle of the ball.

Q. Mrs. Auerbach, you said that when there isn't a strike on at least Sidney Auerbach travels to work by taking two buses and a change.

Will you explain to the Court how he learned to
[8-50] travel those buses?

A. Well, I don't need to say how scared I was when they first said that Sidney is going to have to take two buses to go to work — how is he going to cross Broad Street or York Road?

And they have trained staff that help these boys out and they explained to me what they do. When they moved from Chelten Avenue to Crescentville Road they had an entirely different route to go to work.

One of the staff gets on the bus with them and shows them certain spots that they pass as landmarks, and I suppose they continue that for about a week until they are sure that the boys feel certain that they will know how to get there.

After that, she follows them. They get on the bus themselves, but she follows them in her automobile just to see that they get off at the right place; and that goes on for a week or more until she is certain that they are sure of knowing how to get there. After that they are on their own.

Of course, they have identification cards and they take two buses and when they get off, I think it is 23rd and Hunting Park, they have one block to walk, to 24th and Westmoreland; and they work in the workshop.

They are through there around four-thirty. I think it is from eight o'clock to four-thirty.

Q. Is Sidney going out to adult class at Girls High to learn other things?

[8-51] A. Yes, Wednesday night. Last night was Wednesday. They were there; the minibus took them and the complaint was that they got out a little too early, so the minibus wasn't there for them when they were ready to go home, so they were probably in some drug store having sodas.

Q. What is your son learning at the class at Girls High?

A. At the PARC workshop he packs things. This is a —

Q. I am sorry.

A. What he is learning in Olney High School. It's the Girls High School. It is Broad and Olney, the Girls High School, and he was taught how to cook.

As a matter of fact, last summer, at the closing session, I was invited to see what they had done and I went there. They had all kinds of cakes and salads on display that the boys had made.

Q. And what are they teaching him now?
A. They teach him — they try to teach him how to read and how to tell time and he does take to learning. They can teach him things because the things he is doing now I would have never believed that my second son would have been capable of doing these things.

He's learned more in the three and a half years than he did in the thirty-eight and a half years he was in Pennhurst.

[8-52] Q. Tell me, what differences have Sidney's new life made to you?
A. I don't know where to start, but I can tell you that I have peace of mind. I know that my Sidney is on the right track, that I don't have to worry about what's going on because listening to some of the things this morning brought back to mind bad memories that I don't wish to recall and there is no comparison to how I feel about Sidney's life now in comparison to what it was when he was in Pennhurst.
Q. How —
A. It's all to the good. I mean he is leading a normal life. He gets on the bus to go to the barber shop himself and he knows when he has to go to the barber shop.

He buys his clothes and they make up their own shopping list and they shop and he is doing the cooking.

The three boys — each one takes a turn doing the cooking, but he sees to it that the kitchen is cleaned up after all the cooking is done.
Q. Mrs. Auerbach, will you tell the Court how Sidney came to be at Pennhurst way back in 1937?
A. Well, Sidney was born in December of 1925 and in August of 1926 I was told by my doctor, a pediatrician, that Sidney was mentally retarded and that he would never develop. As a matter of fact, the doc-

tor decided that he would never see and he would never have teeth.

[8-53] Now the boy was only eight months old. My other boy was four years and nine months old at that time, healthy, a healthy specimen, thank God.

So he said I know you are not going to listen to me, you are going to start spending your money. Don't do it. Save it and send this boy to college.

Well, of course, the very next thing I did was go to another doctor and I went to many, many doctors and the answer always came out the same; but who can put away to Pennhurst or any institution a child that's eight months old, so we kept him home.

Q. What was the answer that came out the same? What did each of the doctors say?

A. Each of the doctors said the answer was the same — the boy has to be put in an institution — and we weren't going to put our boy in an institution when he was eight months or a year or two years.

And then he was six years old and I wanted to put him in the public schools and there was absolutely no place in the City of Philadelphia for my Sidney.

We finally found some kind of a special class in a school, the Elverson School, that's what it was called, at 13th and Susquehanna, and we lived at 17th and Susquehanna at that time.

So he attended that class for two — so for two
[8-54] years I walked four times a day those four blocks to take Sidney to school and bring him home.

And the only reason she kept him the extra year is because he was well-behaved, but he made no progress whatsoever.

Well, after that, we started thinking about putting him away and that was a terrible decision to make, so it took almost two years for us to make up our minds to put Sidney away because then it was impossible to keep him home.

Our other boy was getting isolated. He wasn't bringing any friends in the house. It was not good, so we decided to put him in Pennhurst, hoping against hope that someday something good will happen and that he can come out and lead the good life, lead a normal life.

And that was it, but there never was any kind of a program until the Nippon Association came into being in, I would say 1967, when they started to talk to me at Pennhurst about taking Sidney out and putting him in a group home. This was a shock to me.

Q. It was shock?

A. Yes.

Q. What did you think when it was first proposed?

A. How is Sidney going to live, integrating into the community, after being in an institution for thirty years? He was out thirty-eight years.

[8-55] When he came, he was there thirty-eight years when he came out, so this had to be like thirty-five or thirty-four years, for most of his life in an institution and then to put him in a place where he is going to be an individual and take care of his own needs? I can't — I couldn't figure that out, but they had to talk to me too.

They did and I am glad I listened to them.

Q. At first you resisted the idea?

A. I certainly — I didn't resist it but I kept saying how is it going to be, how is he ever going to be able to lead a normal life when he has been leading a sheltered life.

Q. Were you worried?

A. I was terribly worried. I was terribly worried.

This young man who was his counselor at that time — when I heard the names of the buildings that the young men just mentioned my Sidney was in all of them. He was in L-3, L-2, and then he ended up in — at that one up the hill, Penn Hall.

Penn Hall 2, that was supposed to be good already because I think they had like twenty-five boys on a floor.

Q. Instead of —

A. Instead of 150 or 160.

Q. You said you were worried when it was proposed.

Would you say you were scared when it was proposed that Sidney come out?

A. Yes, because I am a widow. My husband died in
[8-56] 1966 and I was left, and my oldest son moved to Atlanta, Georgia.

I really had nobody here to talk to. Well, I have two sisters and they are both widows and they have got their own troubles.

I didn't know what to do. I didn't know what to do and I was scared that the change would be for the worse, but I was told that Sidney has the potential and that he is entitled to have that opportunity to live the normal life, even if we think right now that he can't, he is entitled to that opportunity.

Q. And so you said yes?

A. So I said yes; that's right.

Q. When did you stop worrying?

A. Well, when they really got the wheels rolling about taking him out. I would say he came out in October of '73, I would say offhand, like you say, April of '73, this young man who was his counselor, his first name was Tom and I can't remember his last name — he became like one of my family. I had him down for lunch and for dinner, I don't know how many times, because he wanted to talk to me to make sure that I feel right about it.

And I finally said okay, Tom, let's go, go ahead; and he did and Sidney came out on October 31, 1973.

That house on Chelten Avenue is around the corner from where I live, and the Nippon Associ-

ation were responsible for this change and the executive director of that organization called me and
[8-57] said, "Now, look, Grace. You stay away from Sidney for two weeks. Stay away until we tell you it is all right to come and visit him."

I could see the bedroom from my apartment, so it was pretty hard for me to stay away, but I did, and I didn't have to wait two weeks.

They called me up about a week afterwards and they said it was all right, would I like to come and have dinner; and this was a home. They had a wonderful woman in charge and she called me up and asked me what Sidney likes best to eat, and I told her and she made sure that she had that, because I didn't dare to call up that night when he came, but I had a friend of mine call up to see how is Sidney reacting. He ate and he was happy, so, of course, I was happy.

Q. When did you become very confident that Sideny was going to make it in the community?

A. Well, Sidney had to cross York Road, and I couldn't see that with the two-way traffic, so they'd call up he was coming over and I'd be downstairs waiting for him, and I was a little bit late getting downstairs to meet him.

And when my door bell rang there was Sidney. He walked into the lobby, he pushed the button for the elevator, and he found my apartment by himself; so after that I didn't have to worry.

Whenever Sidney wanted to come over he
[8-58] came over and that was it and that's how it is, your Honor.

Where he is living now he takes one bus, the K bus; he knows where to get off and there he is.

Coming back he has to walk three blocks to take the K bus and he does that.

But most of the time he comes over with his friends. I have them over for brunch on Sundays and I will when the buses will start running again.

[8-159] **Testimony of B. Hare**

* * *

BETTY HARE, having been duly sworn, was examined and testified as follows:

MR. LASKI: Dr. Hare has been qualified as an expert in mental retardation, in the education and training and other habilitation of other mentally-retarded people, and evaluation of programs for the mentally-retarded and the design and conduct of research in habilitation programs for the mentally-retarded.

Just as previously with the testimony of Dr. Flueck, the records shown for the sample study survey that Dr. Hare will be testifying about are in the courtroom for the examination of the defendants, if they choose.

DIRECT EXAMINATION

BY MR. LASKI:

Q. Dr. Hare, did you participate in designing the conduct of a sample study of Pennhurst records?

A. Yes, I did.

Q. And what was your role in that study?

A. John Flueck supervised the quantitive analysis and I designed and supervised the qualitative analysis of the records.

[8-160] BY MR. LASKI:

Q. I show you a document marked PARC Exhibit 52. Do you recognize that document?

A. Yes, I do. They are the forms that we used to record our analysis of these records.

Q. And how did you proceed in this analysis?
A. An experience schedule in program design and delivery was assembled. The members included Eleanor Elkin, past president of the National Association for Retarded Citizens and the current chairperson of the National Association's Residential Services Committee, a consultant to the Joint Commission for Accreditation of Hospitals for Community Services and a qualified and experienced evaluator of programs for mentally-retarded people, under several evaluation teams, including the Program Analysis of Service Systems.

Carla Morgan, who for several years was Director of Community Programs in Bucks County, a member of the Bucks County MH-MR; for several years director of the Westmoreland County Association for Retarded Citizens and director of its programs, and again a qualified evaluator.

And Deborah Spitalnick a doctoral candidate in clinical psychology with extensive field experience in programming for retarded people at St. Christopher's Hospital for Children, Woodhaven Center, and the Fernald State School and Hospital in Massachusetts.

[8-161] Miss Elkin is a consultant to the Public Interest Law Center. Miss Morgan is an employee of the Public Interest Law Center.

Among us we spent 230 hours rating and analyzing these records an average of nearly two hours per record; and another forty hours planning and summarizing our findings.
Q. And what were the focal questions of your study, Dr. Hare?
A. There were four focal questions.

First, we looked to see whether there was current multidisciplinary assessment; second, whether there was a program plan; third, whether there was

an individual plan; fourth, whether there was evidence in the record of regression.

For the current multidisciplinary assessments we asked whether there was full, partial, or no assessment at all, That's Question Number 1 on this form.

Our criteria for decision were whether there showed on the record a determination of the client's strengths and weaknesses, skills and definits, learning styles or present learning functioning at a given time by all the disciplines relevant to such a determination for that person.

Our criterion for current was a two-year period or January of 1975. This is, indeed, a minimum standard. A long-standing professional standard would require annual assessments.

Title 19 of the Social Security Act requires an-
[8-162] nual assessments, as does JCAH and an array of court decisions based on those standards, both in treatment and in education.

In applying these criteria we sought at each point of judgment to resolve in favor of the presence of the item. For the current program plan we asked whether there was a full, partial, or no program plan at all. That's Question Number 2 on the form.

[8-163] THE WITNESS: The criteria for decision were, considering the assessments, whether there was present (1) the identification of long and short-term goals, including priority goals, and the specification of objectives necessary to achieve them, all expressed in behavioral terms;

(2) The specification of the conditions under which the client will achieve the objectives, including the site, the person responsible, the materials to be used, and the teaching methods employed;

(3) The specification of the criteria for evaluating mastery of this objective; and

(4) Specification of the method for recording progress toward mastery.

These criteria again are commonly-accepted professional standards. Many of the witnesses who preceded me spoke about them and their justification.

We have learned, in fact, that in order for systems to be attractive these components must be there. These are the kinds of things I require of my students in teaching.

Again, applying these criteria, every benefit of the doubt was made in favor of its existence and any
[8-164] indication we recorded as partial. In order for a full program plan to be accredited all elements had to be evident.

For the exit plan, which is Question 3 on the form, we asked whether there was a full, partial, or no exit plan at all. The criterion for decision was the presence of specifications of the program necessary for the person to live in the community, including a place to live, activity during the day, and health and other supportive services.

Further, we looked for specification of the person responsible for the coordination and implementation of the plan; and again we were very generous in scoring.

For evidence of regression we asked whether there was in the record explicit evidence of regression, that is, statements by Pennhurst staff that, for example, a client had lost skills once possessed or that maladaptative behavior or symptom was worse or more frequent than it had been; or, for example, the juxtaposition of two statements — first, a statement that a particular behavior exists, such as John

speaks in sentences, and then a later statement that might have referred to this non-verbal boy.

Page 3 of the form shows that we required such evidence in respect to eight areas of behavior — speech, social interaction, toileting, washing, showering, dressing, eating and mobility.

We scored the presence of regression as no in-
[8-165] dication or yes.

Then this measure itself is conservative. No indication is really not to say that no regression occurred, but merely that it was not found.

BY MR. LASKI:

Q. Dr. Hare, I show you document marked PARC Exhibit 53. Do you recognize this document?

A. Yes.

Q. What is that document?

A. This is the results of our study.

Q. Will you briefly read what the tables show?

A. Yes.

Table 1 denotes the findings related to multidisciplinary assessments.

We find that no clients had a full multidisciplinary assessment. 79.4 percent had partial assessments and 20.6 percent had no assessment since January of 1975 at all.

We were surprised that there were no multidisciplinary assessments and so many with nothing at all. The partial group is a large figure. If we had been able to predict this in the beginning we would have coded much more specifically.

I think it is important for you to know what the bulk of partials look like. The evaluations were
[8-166] mostly from Psychology, from Occupational Therapy, and Speech and Hearing. Only rarely was there a section by the vocational adjustment service, special education, or self-care.

Table 2 on this form sets up the results of the program plans. Again, we found that no client had a full program plan; 71.1 percent had partials; and 28.9 percent had no program at all.

Where some elements of the program plan occurred they tended to be the annual program review form, the annual commitment review form, and reports of team meetings.

In most cases the people who did the assessments were not present. The psychologist was there but the occupational therapist and speech and hearing therapists were not. Thus, even the partial program plans were not, as should be necessary, based on the partial assessment.

The partial program plans most frequently included a statement of goals or objectives. The statements were seldom precise and seldom in measurable or behavioral terms.

For example, one that we encountered quite frequently was, "To increase environmental stimulation", or "To encourage family involvement." They do not state what the client should do, where he would do it, or how he would do it or how we would know if and when he had done it.

The other element-specification of conditions,
[8-167] criteria for mastery and documentation of implementation, was virtually non-existent.

In only one case was the client present at his program plan. In no cases were parents there. There was no indication of the presence of a Base Service Unit representative.

Table 3 reflects our findings on the exit plans. Again there was no full exit plan for any — zero percent. There were partial exit plans for 39.2 percent and there were no exit plans for 60.8 percent.

Whenever there was recorded evidence that a group home or foster home ought to be actively pursued this was credited as a partial plan. For example, if they said movement to Woodhaven, so he could have one-to-one involvement, we gave that partial credit.

In virtually no cases was there specificity of the sort of placement or the sort of programs that ought to be provided by the community and no specifications of who should be responsible for the placement.

Table 4 on this form reports the documentation of evidence of regression in the records of 34 percent of the Pennhurst clients. There was no documentation in the rest. However, it does not necessarily follow that no regression occurred in the other 66 percent. It was only not explicitly noted in the record.

[8-168] Q. Dr. Hare, have you had the opportunity to read the records of Charles DiNolfi, David Preusch, Jo Suzanne Moskowitz, and Robert Hight, individual plaintiffs in this case?
A. Yes, I have.

Q. And are these training and evaluation records characteristic of the 124 records that you studied?
A. Yes, they are.

Q. Will you please tell us of the characteristics which those records share with the 124 records studied?
A. They are typical of the entire group in many ways. There is a general lack of multidisciplinary assessment, at best partial program planning and exit plans and notations of regression.
Q. Is the Charles DiNolfi record typical of the 124 you have studied?

A. Disciplinary assessments include psychological and speech and hearing evaluations. In Mr. DiNolfi's case there were also recently-completed forms for an annual program review and an annual commitment review. Neither of these noted the exit plan, except both, to remain as committed until he is able to move into a group home in the community.

I found ample evidence of Mr. DiNolfi's ability to move into the community.

I would like to leave my notes for a moment and state that I feel as if I know these individuals very
[8-169] well, though I have never met them.

Mr. DiNolfi is the kind of man that I really admire. There is ample evidence in that record that this is a man who, despite many handicapping conditions within himself and outside of himself managed to beat the system. Example:

His program is essentially free time, which has allowed him to learn to go about the entire Pennhurst campus unescorted. He knows which buildings he can enter and which he is not allowed to enter. He knows when to go back to his unit — mealtime. He has learned that whole Pennhurst community and managed it on his own.

The record states that he enjoys going to the canteen. He uses money in that canteen to buy food, to buy soft drinks.

There is also evidence that he has learned how to manipulate people. He knows how to get money by approaching; he knows the right people to approach, all of this despite the fact that he has very minimal expressive speech.

Back to my notes.

Mr. DiNolfi has developed discrimination and problem-solving ability. One the psychology report

dated September 19, 1975, I quote, he will remove another resident's article of clothing if it is inside-out, but replaces it correctly.

[8-170] I found this particularly interesting because scattered throughout the ward notes there are frequent notations as to Mr. DiNolfi removing clothing from other people. There were also notes that Mr. DiNolfi "steals" clothing and hoards it.

Further reading provided some evidence that this man is very particular about his appearance. There are frequent mentions that his clothing fits, that he insists on being neat, and he continuously searches until he can find the kind of State clothing in which he is comfortable. Again, this is evidence that this man could be quite self-sufficient.

Back to my notes.

Although the speech evaluation refers to his using speech in both single words and phrases throughout the evaluation, the recommendation was to teach him manual language. This attempt was terminated after six months because Mr. DiNolfi "lacked interest".

I could react to that.

Q. Would you please react to that, Doctor?

A. As a schoolteacher, once she has evidence of a skill that automatically provides a basis for intervention and training, if a person demonstrates something you know he can do it. It is true with certain handicapped individuals who may have hearing we have been attempting some manual language and signs. This is, however, primarily for those persons

[8-171] whose expressive language is almost completely non-existent, usually because of some emotional factor such as an aphasia or an autistic-like condition.

The fact that for some — more than thirty-five years — Mr. DiNolfi had, although very limited, some verbal speech, I would question whether or not to introduce a whole new system would have been the appropriate intervention, but I would have suggested that continuing work with the basic speech that he already had should have been the basis for further extensions of that.

Now I may be responding inappropriately to this because all I have, as I say, is the record; but again from my professional viewpoint, I would have questioned that and I would have certainly been concerned if that was a unilateral decision and not a team decision that signings should have been the appropriate speech development for him.

Q. Dr. Hare, how is David Preusch's record typical of the 124 records you went through?

A. David's record recorded quite direct current assessment shows quite minimal as only audiological and speech evaluations were found. His program plan is only partial also. The goals identified on July 10, 1975 included independent toilet training, dressing, self-help skills, and to correct David's walking with physical therapy and the aid of a brace on the right leg.

It does not specify, except under the umbrella [8-172] term "self-help", but there was an earlier plan for tooth-brushing, which was terminated on January 28, 1975 because he made "minimum progress".

There was no exit plan.

Regression was noted in his feeding skills, a ward note dated 1974 stated he can feed himself while in February 1975 there is a statement, "At one time he would feed himself fairly good. Now he won't even feed himself."

There were also conflicts between gains made and recorded on the school record which were not transferred to his ward behavior.

Q. Dr. Hare, would you please tell the Judge how Jo Suzanne Moskowitz's record is typical of the 124 records you ran your study on?
A. Jo Suzanne's records record only audiological and social service evaluations during this current period, so her record was scored a partial for multidisciplinary assessments.

Again, I think I know this little girl. At a team meeting on March 9, 1977 attended by a psychologist, speech therapist, occupational therapist, social worker, resident life aide, nursing staff member, and someone referred to act as IS representative, it could have been any number of persons.

The goals stated were self-help skills and to decrease soil-smearing and clothes ripping.

[8-173] These were the same goals that appeared on her first program planning six years prior to that date. The DU plan was scored as partial. This was one of the bases of the following statement:

Placement at Pennhurst to continue until an alternative, such as Woodhaven, could be accomplished.

I must comment I was even hesitant to give that partial credit because that is not really an exit plan; it does not meet the criteria.

Again and again throughout the records that I saw evaluated I noticed a paucity of communication among the personnel of the various disciplines and a lack of program implementation when it is obviously warranted.

I mentioned that I felt that I almost knew Jo Suzanne. There are some very interesting comments made by ward workers and teachers, a very heartening one appeared. This was Jo Suzanne's day. The teacher assistent had put her on the toilet. Jo Suzanne reached for something, the teacher stopped her, and said don't, you might break it; and Jo Suzanne said, "break it" and the aide had to re-

peat it again and again, three times in succession. Jo Suzanne, a child who was considered to be non-verbal, said "break it" clearly; and the way the teacher statement wrote and documented this was really very heart-warming.

There were also references in the record as to
[8-174] her saying "okay" and hummed Christmas carols and happy birthday, yet there is no indication of a program to enhance expressive language, only the fact she doesn't have it.

Q. In your view of [Moskowitz] record was there any notation of any follow-up on the aide's indication of speech?

A. No reference, no.

There are reports that in school she has few toileting accidents, no ripping; she is learning there to dress herself and to use a spoon. In school she can identify colors, do puzzles and other fine motor activities. She identifies objects when they are named and she follows verbal directions.

I found no evidence of follow-ups on these skills on the ward.

If I am interpreting this correctly it says to me that when [Moskowitz] is off the Pennhurst grounds in a classroom she is functioning, she has skills. I found nothing in the records to demonstrate evidence of these skills in Pennhurst.

Q. Dr. Hare, was the evidence of speech detected in the schoolroom, away from Pennhurst?

A. There was a notation in the school record and there are specific sheets that are school records themselves that denote this, yes.

Q. What did you find in Robert Hight's record that was typical of the records that you analyzed?

[8-175] A. Robert Hight, of course, lived at Pennhurst for two and a half weeks. The only assessment was a psychological evaluation done on September 24,

1974. There was no program plan nor commitment plan. There was apparently, from the ward notes, some physical deterioration.

There was also a very interesting occurrence that I noted on Robert's record. There are two psych reports. The second is completely identical to the first with one difference. There is a statement about the attitude of the parents. A memorandum ordering the deletion of this sentence, although it was not removed but noted merely as erroneous is dated January 16, 1976, over a year after Robert was removed from Pennhurst.

I found a notation of September 30, 1974 also very interesting. Now this is four days after Robert left. "The Hights were overreacting to a normal adjustment period that Robert has to go through."

The ward notes for that period included the following, September 22, 1974, "He fell, sustaining minor lacerations, lower lip."

For September 26, 1974, "Slid out of wheelchair, sustaining an abrased upper right arm."

Q. Dr. Hare, in your review of the records did you note the extent and nature of the involvement of the county Base Service Units and program planning and an exit planning for a Pennhurst resident?

[8-176] A. Yes. In no cases was there recorded evidence of BSU participation in program planning. The representatives of the Base Service Units were not there.

In approximately twenty percent of the cases there was recorded some contacts with the BSU and such entries were reported on the annual commitment forms, which asked what BSU participation there had been.

I have read in the deposition of Catherine Clark, the Chief of Social Services at Pennhurst, that all Pennhurst residents have been assigned through BSU. Letters have been sent from

Pennhurst to BSU inviting their participation and giving us a copy of the annual program reviews and annual commitment reviews.

The retardation center received unique replies among the BSUs, which turn up on the records. Approximately a dozen times these were cited as having visited their clients at Pennhurst for purposes of formulating a life-management plan for the person. Sometimes there appears on the record a copy of the Montgomery County on-site evaluation.

Q. Dr. Hare, what is a life-management plan?

A. The BSUs are supposed to prepare for each of the clients a life-management plan, including those in institutions. This is a long-term habilitation plan specifying services for that person from birth to
[8-177] death, including those necessary for that person to live in the community.

Q. Apart from the Montgomery County Mental Retardation Center, what do the records reflect which are in the Base Service Unit contact and involvement?

A. Over and over again the records note contact from Pennhurst to the BSUs and no response from the BSUs. This is in approximately eighty percent of the cases.

The remaining twenty percent include the Montgomery County visits that I mentioned. The rest are simply comments about the unavailability of community services. For example, I'd like to read some of these.

In Case Number 7041 the following comments appeared on the record dated 1976 — since there are presently no appropriate alternative living arrangements, he will continue to remain at Pennhurst for further care and training. No life-management plan from the BSU has been received as of this date. For Case 9704 in 1976 — Father is interested in John's welfare and takes him home

frequently for vacations. At the present time there are no plans for community placement from the BSU.

For Case Number 9862, this is a report dated 1972 — Betty would function in a group home setting if appropriate schooling, clothes, workshops, and transportation were available.

Four years later in the annual commitment report of 1976, which was sent to the BSU, the
[8-178] Pennhurst staff noted lack of alternative; commitment continued.

For Case Number 5189, from the 1976 annual commitment review — BSU letter says appropriate community living arrangements not presently available. Recommend he continue at Pennhurst.

* * *

[8-184] Q. Dr. Hare, did you have the occasion in the course of your work to commission and/or see a tabulation of program hours delivered for sixty-eight Pennhurst residents who at one time in the past were considered for transfer to Embreeville?

A. Yes.

Q. And from what work record was that tabulation made?

A. From the answers to interrogatories by the Superintendent of Pennhurst, Duane Youngberg, setting forth the programs delivered to the sixty-eight persons during their years at Pennhurst and the hours that were spent in those programs.

Q. Dr. Hare, I show you a document marked PARC Exhibit Number 54.

[8-185] Do you recognize this document?

A. Yes, I do. It is the analysis.
Q. Have you summarized from the cover sheet of the analysis the findings?
A. As of December 1976 the sixty-eight people had been living at Pennhurst an average of 21.92 years. Programs reported by the superintendent included certain unstructured activities, such as free time and certain services such as public school and outside workshops, which were not provided by Pennhurst. Nevertheless, all entries for all programming were included in this analysis.

Many programs were reported without any duration or hours. These were not included. Approximately one out of eight programs had no hours reported.

The average time between the clients' admission and the first reported program with hours attributed was 18.8 years.

The total number of hours of programming reported by the superintendent for the sixty-eight people was 65,047 hours. The sixty-eight people have been at Pennhurst a total of 1,490 years; thus they are reported as having received 43.65 hours of programming per client per year. This translates to 7.2 minutes per client per day.

For the three years, with the programs with attributed hours, sixty-eight people were reported as
[8-186] having received 318 hours of programming per client per year. This translates to less than one hour per client per day.

* * *

Q. Dr. Hare, in the course of your work did you have the occasion to oversee a tabulation of the characteristics of persons on the waiting list for Pennhurst?
A. Yes, I did.

Q. And from what records were those tabulations made?
A. From the list of people on the Pennhurst waiting list since May of 1974, again provided by Superintendent Youngberg.
Q. Dr. Hare, I show you a document marked PARC Exhibit 55. Do you recognize that document?
A. Yes, I do.
Q. What is that document?
A. This is the waiting list representing a total of 2,328 persons.

Table 1 describes the level of mental retardation of the complete count. It shows that of the people on the waiting list, 20.3 percent fell into the mild range of retardation; 24.3 percent fell into the moderate range; 16.1 percent in the severe; and 7.8 percent into the profound range.

31.5 percent were listed as unmeasurable or unknown.

Table 2 is distribution of age on the basis of a sample of 700 persons on this list. 41 percent fell between the ages of birth and sxiteen; 17 percent be-
[8-187] tween seventeen and twenty; 23 percent between twenty-one and thirty-four; and 10 percent were older than thirty-five.

The approximate mean age of the persons on that waiting list was twenty years.

Table 3 denotes the current placement status on the complete count. 4.7 percent of these persons are at the present time in another Pennsylvania State Institution. 31.4 percent are in another facility, that is, a private licensed facility or a foster home, which would be Elwyn, Pine Hill Penncrest, and so on. 64 percent of them in number are at home or placement unknown.

* * *

[9-51] **Testimony of Winifred Halderman**

WINIFRED HALDERMAN, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. FERLEGER:

Q. Mrs. Halderman, what county do you live in?

A. Bucks County.

Q. And how long have you lived there?

A. Since 1947.

Q. You are the mother of Terri Lee Halderman, —

[9-52] A. Yes.

Q. — the plaintiff in this case?

A. Yes, I am.

Q. When was Terri born?

A. July 29, 1953.

Q. Did you know at the time that she would be retarded?

A. Not exactly, no.

BY THE COURT:

Q. Is that 1963?

A. 1953.

BY MR. FERLEGER:

Q. At what point in her early development did you see any signs of anything abnormal?

A. In and around a year.

Q. I can't hear you.

A. Around a year.

Q. And what did you notice then?

A. Well, she just wasn't developing as fast as she should for a child of her age.

* * *

[9-57] Q. What occasioned her transfer to Pennhurst in February 1966?

A. The private home felt they could no longer handle her, she was getting too big.

Q. Was there any other community care to which they referred you?
A. No, there was not.

Q. When Terri Lee was transferred to Pennhurst was she placed on a ward with other residents who were able to walk or was she placed on some different sort of a ward?
A. In the beginning she was placed on a ward where they walked.

Q. And then what happened?
A. And then a short time later they said that Terri didn't adjust to that ward, so they moved her to the crib ward.

Q. And was she kept in a crib?
A. Most of the time, yes.

Q. Even though she could walk?
A. Right.

Q. Do you recall the name or number of that crib ward?
A. I am not sure, I think it was C-13.

Q. That would have been C-13 that she went to in March of 1966?
A. This would be it.

[9-58] Q. I note from the records and defendants' answers to interrogatories regarding Terri Lee Halderman that she remained there until about April 1970.

* * *

BY MR. FERLEGER:

Q. Will you describe what you saw, heard, felt, and observed on Ward C-13?

A. C-13 wasn't a very nice matter. It was very depressing. It smelled very, very bad.

Q. What did it smell like?

A. Urine and feces. There are just rows and rows of cribs with just barely enough room to get between.

There were many, many flies in there crawling all over the residents. They would crawl around their mouth and all over their body and a lot of them didn't have enough knowhow, how to get rid of the flies off of them, so they just laid there and they crawled all over them.

Q. Did the aides engage in any activities that you observed on that ward?

[9-59]

A. I never observed any, no.

Q. The aides didn't do anything about the flies, for example?

A. No. There were too many of them.

Q. About how many aides were on duty when you would visit?

A. I think there were usually around three, two or three.

Q. Were there any programs on that ward for Terri Halderman?

A. No, there wasn't.

Q. How do you know?

A. I never saw her in any activities at all.

Q. How frequently did you visit?

A. Usually once a week on Sundays.

Q. Do you recall whether Terri Lee Halderman suffered any injuries in that period of 1966 to 1970?

MR. GOLDBERG: Note my objection.

THE WITNESS: Not to my knowledge. I can't remember.

BY MR. FERLEGER:

Q. During that period was there any problem that you noted or that Pennhurst noted regarding Terri Halderman's weight?

A. Well, Terri Lee was quite thin. I don't feel she got enough to eat at Pennhurst.

Q. Let me just briefly read you some information and ask you for your response.

In response to Interrogatory Number 18 of the
[9-60] plaintiffs regarding Terri Lee Halderman the question was give weight and height of plaintiff on admission and weight and height at yearly intervals since admission.

The defendants answer:

No information regarding height, but this information regarding weight:

1967, sixty-five and a half pounds;
1968, sixty-three pounds;
1969, eighty-one pounds;
1970, eighty-one pounds;
1971, eighty-one pounds;
1972, seventy-five pounds;
1973, ninety-three and a half pounds;
1974, eighty-nine pounds.

Now how old was Terri Lee in 1966 when she went into Pennhurst, approximately?

A. Twelve years old.

* * *

[9-62] BY MR. FERLEGER:

Q. Did you make any complaints to any officials at Pennhurst regarding the weight loss that Terri Lee exhibited?

A. Yes. I spoke to Dr. Youngberg, Dr. Smilovitz, and I also spoke to Mrs. Cawley.

Q. Did Dr. Smilovitz or Dr. Youngberg, if you know, take any action to check whether or not she

was getting appropriate food or to check on her weight?

A. Yes. Dr. Smilovitz made them take a daily — I asked for a weekly weight check, but when he requested it he asked for a daily weight check on Terri's weight to make sure she is getting the proper amount of food.

Q. Did he say why he requested daily rather than weekly?

A. He said that way he knows that it is going to be taken care of every day.

Q. And did they find out whether or not she was getting the appropriate portion of food?

A. As long as they kept after them she got the appropriate food, yes.

Q. The responses to Interrogatory Number 1 indi-
[9-63] cate that Terri Lee went to Ward C-3 in May of 1970 after she came from and she remained on C-3 for certain hospitalizations until October 1971.

Could you describe Ward C-3?

A. C-3 was a ward that was on the first floor, a very large ward, another ward that was very drab, very smelly.

Q. What did it smell like?

A. Urine and feces.

Q. Did you see any urine on the floor?

A. Yes. There was urine on the floor nearly every time I went in.

Q. Were residents dressed or undressed?

A. Some were dressed and some were undressed, but they never had shoes and socks on.

Q. Was Terri Lee Halderman fully dressed?

A. Sometimes yes, sometimes no.

Q. When she had a dress on would she have been dressed in underwear or not?

A. Sometimes she'd have underwear on, underpants would be all; and other times, no, which was quite embarrassing.

Q. Embarrassing for whom?
A. My young son that went to visit with us.
Q. Did you ever complain about that?
A. Yes.
Q. Did things improve after your complaint?
[9-64] A. No.
Q. Now in the summer of 1971 did you have occasion, on C-3 to visit any resident who was lying on the floor?
A. Yes. That was around the time of my daughter's birthday and we had taken her out to Valley Forge Park to celebrate her birthday.

And when I took her back to her ward there was a resident sitting on the floor with her face down on the floor, in urine, so I brought it to the attention of an attendant who was there and she said yes, they —

MR. GOLDBERG: Objection.

BY MR. FERLEGER:

Q. And you brought that to the attention of patient-care workers?
A. Right.
Q. And did she agree with the facts that you observed?
A. Right.
Q. Did you ever speak to Dr. Youngberg about that?
A. Yes, I did.
Q. And what was his response?
A. Well, I told him about that and I also told him about the same resident that was on the floor with her face in the urine also went into the bathroom and ate the feces out of the john.
Q. What did Dr. Youngberg say?
A. Dr. Youngberg said that shouldn't be and he
[9-65] would see that condition was corrected.
Q. That was in 1971?

A. Right.
Q. I notice from the records that Pennhurst called Terri Lee Halderman a head-banger.

Now before she went to Pennhurst would she ever bang her head at home?
A. Well, Terri Lee is non-verbal and about the only time she would bang her head would be at night, when she had gone upstairs to go to bed. She'd go to the wall in the hallway and just give one bump, as if to say good night.

If she wasn't feeling well she sould bump her head to let us know that things weren't right.
Q. And then once you took action she would stop?
A. She would stop, right.
Q. She wasn't a constant head-banger so that she would get injured as a result of it?
A. No, no.

* * *

Q. What was the hospital's response to the head-banging?
[9-66] A. Well, they just said that she was a self-abusive child when they sent her home.
Q. Did you ever speak with Helen Francis?

I believe she is a nurse and a unit director.
A. Yes.
Q. Regarding the possibility of Terri's head-banging being the result of pain that she was experiencing?
A. Yes. There for a while Terri was banging very, very hard and often, and I was trying to get to the bottom of why she would be banging so bad because this isn't Terri's nature.

One of my questions was, you know, could she be starting maybe with her menstrual periods and, well, they didn't know.

Then I noticed she had a tooth broken off and I asked about the tooth and that was supposed to be taken care of but it wasn't done when it was supposed to be, and I thought maybe she was having pain in the jaw.

Q. And what did you discuss with Helen Francis? Those types of things that you have just mentioned?

A. Those things; right.

* * *

[9-67] Q. Did Terri Halderman have water available to drink on her ward as she desired?

A. There, I will put it this way. I spoke with them, both Miss Francis and Miss Cawley, and I believe Alex Mansfield on the water situation.

I was told by each one that there were water fountains, a large and a small one, on each of the units; but what they don't seem to understand is that most of the residents there don't know how to use the water fountain, so, therefore, they didn't get water.

Q. Did you ever see Terri Lee Halderman using the water fountain?

[9-68] A. No. She didn't know how to use the water fountain.

Q. Do you know if there were any programs in effect to teach her how to use a water fountain?

A. No.

Q. No, you don't know, or no, there weren't any?

A. No, I don't know.

Q. Were there any programs on C-3 for Terri Halderman?
A. Not to my knowledge.

Q. While she was on C-3 was Terri Halderman able to chew regular table food?
A. No. Terri chewed for just a short while when she was in a private home, but when she went to Pennhurst she lost her chewing ability again.

Q. Was she given table food or chopped-up food on C-3?
A. She was given table food on C-3.

Q. Despite the fact that she couldn't chew?
A. Yes.

This was another thing that I brought out about her head-banging. Perhaps she was suffering from the fact that she was swallowing her food whole.

Q. Did Terri Halderman receive any injuries to her fingers on April 9, 1971?

MR. GOLDBERG: Objection, your Honor.
This is probably the most leading question that he has asked.

[9-69] THE COURT: It is a leading question.
Let's talk about whether she ever injured her fingers.
Was that your question?

MR. FERLEGER: Yes, it was, your Honor.
Thank you.

BY MR. FERLEGER:

Q. Would you answer our collective question, please?

A. Yes. Terri Lee had three fingers broken in C-3.

BY THE COURT:

Q. Do you remember about when that could have happened?

A. Terri Lee had so many accidents, your Honor, in around this general time that I really — I really can't keep the dates in my mind.

Q. When would this be, approximately, when you said in and around this general time?

A. Oh, somewhere around probably '69 or '70; right on up until the time she left.

Q. And when did she leave?

A. A year and a half ago, October 30th.

THE COURT: All right. Let's proceed.

BY MR. FERLEGER:

Q. Do you know if the State Police were called in to investigate that injury?

A. Yes, they were.

[9-70] Q. And were you told or given any other notice by Pennhurst officials of the cause of her fractured fingers?

A. No. They said that they really didn't know for sure; they throught maybe she might have gotten them caught in the swinging doors but they had no proof of anything.

Q. Do you know if anything was ever done for those swinging doors on that ward?

A. I don't know. They were supposed to have been taken care of but I couldn't tell you.

Q. Did Terri Halderman at Pennhurst receive any injuries to her jaw?

A. Yes, she did.

Q. And about when was that?
A. That was, as I recall that was maybe six months after the broken finger.
Q. That would be in October 1971?
A. Right.
Q. Could you describe how you were notified of that injury?
A. Yes. I received a telephone call around dinner time that night.
Q. From whom?
A. I am not sure.
Q. And was that when you were notified of the injury?
A. That's right. They needed my permission to be able to operate the next morning.
[9-71] That was the reason for the call.
Q. Did they tell you what the injury was?
A. Yes. She said her jaw was broken.
Q. Did you see Terri Halderman in that state before the operation?
A. Yes. I called them back after I gave them permission on the telephone and asked them what time she was going to be operated on and they told me and I said please not to remove her to the operating room until I could see her. They told me eight-thirty.
Q. Could you describe in detail Terri Halderman's condition at the time you saw her?
A. Yes. Terri Lee is a small — is a small, little girl, very thin-faced; and when I saw her her face was ballooned out like this, and she was quite groggy and probably also was very uncomfortable at the time.
Q. Could you tell whether she was in pain?
A. From the look of her face, I would say yes.
Q. After the operation were there any difficulties in her recovering from the operation?

A. Well, right after surgery she had difficulty in coming out of the anesthetic.

* * *

[9-73]BY MR. FERLEGER:

Q. What did Dr. Wilton tell you?

A. He said that Terri Lee had too — well, was under too medication, too heavy medication.

A. And did he tell you what he would do about that?

Q. Yes. He told the nurse to cut down, in fact, to cut Terri Lee's medication cut that she gets ordinar-

[9-74] ily until he notified her; and also that the dose she was getting was entirely too large for the size of Terri Lee, and when she started to go back on it he started her on half the amount.

Q. Before you left to go home that day did you inquire as to the future care of Terri in recovering from that operation?

A. I had asked them — they had to restrain Terri because she would go back like this with her head all the time and her jaw was broken in three places, so they had to restrain her as much as possible so she wouldn't jar loose the wires.

So they used to take a sheet and twist it around her neck and around her arms and fasten it down so she couldn't raise up to come back.

And I asked them if they wanted to put the sheet on, and they said no, it wasn't necessary.

Q. And then did you leave?

A. Then I left, and I had forgotten something after I got to my car, so I had to go back into the hospital and that fast they had taken a sheet and fastened her down.

Q. You testified earlier about a tooth having been broken off.

How long did it take for that broken tooth to be repaired?

A. Well, I really don't know when the tooth was broken off because I was never notified of it.

Q. How long after you noticed it did it take for it to be repaired?

[9-75] A. It wasn't taken care of until the day her jaw was hurt and I asked the surgeon who was going to do the jaw if he would pull the piece of tooth out, and he said yes.

Q. And what was that period of time, approximately?

A. I am not sure. I'd say maybe around a year, a year and a half.

I am really not sure.

Q. But at least a year?

A. Yes.

Q. Were you ever asked by any employee or official at Pennhurst for permission for the hospital to administer drugs to Terri Halderman?

A. No. In fact, I didn't know for a long time that she was on drugs.

Q. Were you ever told of the effects of any tranquilizing or other psychotropic medication or the side effects?

A. No, I was not.

Q. Did you ever ask about whether she was drugged?

A. No, I didn't, not in the beginning, not until after I knew that she was on medication.

Q. How did you come to know that she was on medication?

A. When I received a letter one day from Dr. Parroco stating that Terri was in the hospital for listlessness and I called immediately to find out what was wrong, why she was listless, had she banged her head, was she sick.

[9-76] And I couldn't get any answer.

Q. You called and spoke to Dr. Norman Parroco?

A. I called and spoke to Dr. Norman Parroco.

Q. As far as you knew he was Terri Halderman's physician at the hospital?
A. That's right.
Q. Did you ever get to speak with him further on this issue?
A. I told him that day that I'd be up to the hospital the next day to see him, that I'd like to have an answer as to what was wrong with her.

And I went up the next day to visit Terri and as soon as I went there I told Mrs. Barto please get ahold of Dr. Parroco, I'd like to talk to him.
Q. Were you told that you could come to speak with him?
A. Yes.
Q. Then what happened?
A. Then Terri started to get a little unhappy and started to cry and they told her that I had gone downstairs with my young son, who had just got out of the hospital from ear surgery, so I went downstairs and told her to have Dr. Parroco come down there and I waited and waited and waited for about an hour and a half and no Dr. Parroco.

So I got on the phone and asked him to come over, but he couldn't come over.
Q. When you called did you speak with him?
[9-77] A. I finally got him, yes.
Q. And you recognized his voice?
A. Yes.
Q. Did he say he would come speak to you?
A. No, he wouldn't come talk with me. We talked on the phone.
Q. Did he explain to you why he wouldn't come to see you?
A. No.
Q. Did he explain at that point what he meant by Terri being hospitalized for listlessness?
A. After many, many minutes, he finally admitted

that she was in the hospital due to being over sedated with Mellaril.

Q. And what was your response?

A. And my response was I was quite angry because my young son at that time was on Mellaril and I asked him what did he know, an overdose of Mellaril? She had to have an awful large dose.

Q. In February 1972, according to the defendants' interrogatory responses, Terri Lee Halderman went to the New Horizons Building. Is that correct?

A. That's right.

Q. What ward was she on there?

A. 47.

Q. And was drinking water made available to Terri Halderman on that ward?

A. Only by the fountain. I brought — pardon?

Q. Go on.

[9-78] A. I had brought it to their attention also, to Miss Cawley, who was my social worker at that time, and she said the same thing.

* * *

BY MR. FERLEGER:

Q. Was Ward 47 a new or an old ward?

A. Ward 47 was a new ward. The New Horizons Building is the newest building there other than the modulars.

Q. Were toys made available to the residents on that ward?

A. They had toys, but they were kept in a closet.

Q. When you visited they were never out?

A. Very, very rarely. Once in a while the ball would be out.

Q. Was there the same amount of urine on the floor?

A. It wasn't as bad in 47 as the previous wards, but there was, yes, there was urine on the floor.

Q. And did the aides take any action to clean that up while you were present?
A. Yes, they did.
Q. Were there any injuries to Terri Halderman's toes in 1973?
A. Yes. Terri Lee had a broken — a broken toe in '73.
Q. Did you ever speak with Dr. Youngberg regarding the cause of the broken toe?
A. Yes. Several weeks before the broken toe
[9-79] Pennhurst was having a shortage of shoelaces and I brought it to the attention of Dr. Youngberg and he said yes, that the State had erred. The institution said the only thing they could order was food and medical supplies, so, therefore, they couldn't order the shoelaces.
Q. Do you have any idea from any Pennhurst officials regarding how Terri's toe was broken?
A. Yes. They told me that she had had —
MR. GOLDBERG: Objection, your Honor, unless she can identify who the declarant was.
BY MR. FERLEGER:
Q. Do you know who told you?
A. I don't know who told me all that.
Q. Were you given any information from Pennhurst which indicated to you that the broken toe was caused by a lack of shoelaces at Pennhurst?
A. Yes, because she didn't have the shoes one. She pulled a chair over on her foot.
Q. On Ward 47 — and we were talking now about February of 1972 until May of 1974 and later, until Terri Halderman was transferred from Pennhurst — were aides in constant attendance with the residents at all times?
A. No, they were not.
Q. Could you explain your answer?
A. Well, most of the time the aides weren't in the
[9-80] day room with the clients. They would either be in

the office or they might be showering someone; if they had had an accident or they may be socializing with someone in the back room.

Q. What number of residents would be left in the day room unattended?

A. Well, there were two day rooms. There would be maybe fifteen or twenty on each side.

Now one side was kept locked and the other side was open so the residents could go to the bathroom by themselves because they were trained.

Q. On the locked side would be residents —

A. Who were not trained.

Q. — who would be locked in the day room with no attendants present?

A. That's right.

Q. How many aides were on duty, either in the office or doing the other jobs you mentioned?

A. Usually two.

Q. Any times less?

A. Sometimes one, sometimes three.

Q. Did the aides have any housekeeping responsibilities as well as child-care responsibilities?

A. Yes, they did. They had to make all of the beds on the ward and on weekends they had to do all of the cleaning because there wasn't any cleaner come in on weekends.

[9-81] Q. Does Terri Halderman at this point in time have all her teeth?

A. No, she does not.

Q. Were her teeth pulled at some point?

A. Yes.

Q. Will you tell us when and why, if you know?

A. Oh, dear. Well, I can't remember the date.

They were pulled about six months after her broken jaw because they had to go back in and do some more work on her gum and at that time they pulled all of her teeth except the molar on the back of each side.

Q. Do you know why?
A. Why they pulled the teeth? Because most of them were rotten.

[9-82] BY THE COURT:
Q. Did you observe her condition after the operation?
A. Yes, I did.
Q. What did you observe during that period, —
A. Well, —
Q. — if anything?
A. There wasn't that much really to observe, except that the swelling did go down. There were no bruises of anything like that, but the problem was the fact that they had to go back in. See, the bone fragments had splintered as a result of the broken jaw and they had to go back in and remove the splinters and the bone fragments because they were afraid they would travel to either the ear or the brain and do more damage.

* * *

Testimony of F. J. Sobetsky

* * *

[9-147] Q. Did your children receive any injuries during the four or five years they were at Pennhurst?
A. Yes, they did.
Q. Would you describe how frequently they received injuries?
A. Well, Robert received injuries practically every week that he was there.
Q. How did you know?
A. Every time I brought him home he smelled so I put him in the bathtub and washed him; and you'd find bruises on him, bite marks on him, scratches
[9-148] on him, any part of his body, in fact, on his rump and on his back legs there were even some welts on them.

And I wondered at that time if he even got beat. I didn't know, but I know he had welts on there and I complained pretty frequently.
Q. You said that he smelled.

What did you mean by that?
A. Smelled from — I'd say smelled from the smell of Pennhurst.
Q. What kind of a smell would that have been?
A. Well, the urine or whatever smell that goes on there in that ward on in those wards.
Q. Did Teresa receive any similar injuries?
A. Not as many as Bobby. I will say maybe Teresa received about thirty percent of what Robert did.
Q. Do you know whether Dr. Youngberg, the Pennhurst superintendent, ever became aware of any of the injuries suffered by your children?
A. I am sure Dr. Youngberg was well informed from my letters of correspondence with him.
Q. Did you ever speak with him or did Robert ever confront him with anything?

A. Did I ever speak with Dr. Youngberg?
Q. About any injuries to Robert?
A. Yes, I did. I tried to get him out of his office one Friday at five o'clock in the afternoon and he didn't
[9-149] want to come out.
Q. Do you remember about how long ago that was?
A. I'd say within the last year and a half that they were there.
Q. And did Dr. Youngberg come speak with you that day?
A. After I told his secretary I was going to go up to the priest and that was the day that Robert was scratched up underneath his eyes, on his nose, on his cheeks, on his forehead.

And when I mentioned that I was going to go to the priest, then Dr. Youngberg did come out to the corridor and said, "Let's get Robert."
Q. He looked at Robert?
A. Yes, he did.
Q. What did Dr. Youngberg say?
A. He didn't say anything. He just says tssk, tssk; and that was about it and shook his head.
Q. Were there any problems with the dental care of Robert Sobestsky?
A. Well, he had a tooth pulled that I didn't even know the reason why it was pulled.

Robert's teeth are darn good. He had a darn good healthy set of teeth and they said he had it pulled.

When I come up to take him home that Friday, I had to wait for him and it was a pretty cold, bitter day, and the aide was carrying him down from the dental office to his ward.
[9-150] His mouth was all bloody. I guess the blood got all over his cheeks, all over his neck, so the aide just looked at me and said, "Don't blame this on me."
Q. Had you been asked for permission to have Pennhurst pull his tooth?

A. No.

Q. Do you know if your wife had been asked for permission?

A. No. My wife has never been asked neither.

* * *

BY MR. FERLEGER:

Q. Could you identify and describing generally what these pictures show?

A. Well, these are some of the conditions that Bobby came home with on weekends.

This one here has two big bite-marks on his back plus one on the back of his upper arm.

I think this is part of the condition when that youngster attacked Bobby in bed at two o'clock in the morning. This picture doesn't do it justice anyway; it was worse than that.

This is a different approach to the bite-mark.

Here is a big black-and-blue mark that oc-
[9-153] curred on his arm.

Here is another bite-mark on his back.

As you say, there never was any openings, but there is a picture saying that there was an opening.

Q. Now did you take these pictures?

A. I took those pictures, yes.

Q. Why.

A. Because Dr. Youngberg didn't want to quit — well, let's say, I can't say Dr. Youngberg, but at Pennhurst no one seemed to understand that the children weren't supposed to be put to this kind of treatment and I believe I notified them that I was taking pictures every weekend when something was wrong with the children.

Q. And what do these pictures represent from the same exhibit?

A. The same thing with Teresa. There is a big blue mark on her lip, on her lips, and a big bruise mark

here, and here is a picture where it shows that she fell and cut her chin, also the conditions after dental care — swollen lips, swollen jaws.

Q. And did some of these injuries happen after, as well as before, you filed the lawsuit in this case?

A. I don't believe I took any pictures after I filed the lawsuit. I just made some notations that I have at home in the book.

* * *

Testimony of Ruth Wood

[10-66] BY MR. RIVERA:

Q. Are you currently employed, Miss Wood?

[10-67] A. Yes, I am.

Q. Where are you currently employed?

A. With the Chester County Association for Retarded Citizens.

Q. What position do you hold?

A. Executive Director.

Q. What is Chester County Association for Retarted Citizens?

A. It is a non-profit agency operated by a board of directors which, in turn, are elected by the membership. It was incorporated for the purpose of helping mentally-retarded children and adults living in Chester County.

Q. Do you know who started it?

A. It was started by a group of parents and interested citizens in 1962.

Q. And the membership, what is that composed of?

A. Parents, professionals interested in the field of mental retardation, and friends interested in mental retardation as well.

Q. Can you tell us the purpose of the Chester County Association for Retarded Citizen?

A. The philosophy is to be interested in and help mentally-retarded citizens, wherever they may be, in an institution, living at home with their parents, in the schools.

We also work with our state and national associations in terms of having interest in legislation, issues, appropriations.

[10-68] Q. And does Chester County Association for Retarded Citizens — can I call that CARC From now on?

A. Yes.

Q. Does CARC run any programs for retarded citizens?

A. Yes, it does.
Q. Can you tell me what type of programs it runs?
A. We have a pre-school program for children from zero to three years of age and we have a group-living arrangement for group homes for retarded adults.
Q. What is the approximate age range of the citizens you serve?
A. In the community-living arrangement?
A. No, overall.
A. From birth to fifty-five.
Q. Okay.

And the level of retardation?

A. From severe and profound to mild.
Q. Are any of these citizens that you serve ex-Pennhurst residents?
A. Yes.
Q. You earlier mentioned that you are the executive director; is that right?
A. Yes.
Q. What are your duties as executive director?
A. They fall into two broad categories — one, I am
[10-69] the administrative head of the services we perform; and the other is the classic role of an executive director in NARC. It is to support the volunteers. It is a volunteer governing board that are my bosses, so to speak, and we are interested in extending the network of services, whether we do it ourselves or see other agencies do it, monitoring the services, working with the schools, and monitoring under the right to education, aiding parents in finding appropriate services for the children, public education on the field of retardation, study of issues, cooperation and prevention, research, work with other community agencies.

And then we, as I mentioned before, work with our state and national associations. You know, we have to raise money to do all of this.

Q. How did you become interested in the field of mental retardation?

A. I have a retarded daughter.

Q. Skipping the pre-school program, let's talk about the community-living arrangements.

Could you describe that for us briefly?

A. Our agency operates three different types of community-living arrangements or group homes.

One is called the long-term shelter and consists of a single residence or house with live-in staff.

The second, which for us is fairly recent, is
[10-70] clustered apartments, which consists of a series of apartments in a large complex, with staff living nearby but not with residents.

The third is minimal supervision, wherein living areas for the retarded individuals — and in our case two to an apartment or one to an apartment — live in the general geographic area and the staff live in that same area.

Q. Let's turn to the long-term shelter.

What is it? Does it have a goal?

A. The goal in a long-term shelter is perhaps for some people to be in a shelter for a long time. For others, it is to train individuals to move into another less-structured environment, and continuing service.

Q. How long has the long-term shelter program been in existence?

A. Our first long-term shelter began in the spring of 1973.

Q. Is one of these centers located in Coatesville?

A. Yes, it is.

Q. And what kind of location is it in — neighborhood?

A. It is in a residential neighborhood, large duplexes, and the house is a duplex which has been converted to a single residence.

Q. Could you walk us through this house, starting with the front door, please?
A. Okay.

As you come in the front door on the right is the
[10-71] apartment of the resident house manager. On the left is a large living room. Behind that is a dining room and then a kitchen, which is used by all members of the house, including the resident manager when he is on duty.

Directly in front of the entry there is a stairway to the second floor and on the second floor are the original bedrooms of the original two houses. There is no access to the second floor from the resident manager's apartment.

There are four bedrooms and two baths and then there is a converted room into a den.
Q. How many people live in this house?
A. Eight retarded residents from several places, and then the resident manager.
Q. And what are their levels of retardation?
A. From mild to moderate.
Q. And how much time do the residents spend within the group in the long-term shelter, let's say a day?
A. Except for the working hours, basically speaking, they are there during the evening hours; first thing in the morning, over the weekends unless they are involved with recreation or something of that sort.
Q. You mentioned during the working hours.

Are they involved in some kind of program of work?
[10-72] A. Yes. Currently all of them are occupied in the local workshop.
Q. And when do they go to the workshop?
A. They leave in the morning to catch a bus, public bus, about 8:15-8:30 and then return in the evening close to — a little after four.

Q. And they all take public transportation to get to work?

A. Yes.

Q. Does the group itself offer any kind of activities for the retarded citizens?

A. Yes. First of all, they have training in terms of learning living skills. They use goal planning and assess the individual as to where he or she might be in their skills and what needs to be done next.

Then, in addition to that, of course they are involved in learning to cook, learning to manage their own money, learning the care of the house, care of themselves and their clothing and so forth.

They learn how to shop and how to make use of the community in terms of recreation and things of that sort.

Q. Are these kinds of services around the group home?

A. There is no doctor assigned to the group home. They go to their own doctor, their own dentist.

They use the "Y". They also, in Coatesville they
[10-73] are fortunate enough in that there is a night-school program in the local high school, an adult school program that they can participate in. That's not true of all — in all of the centers.

Q. What kind of programs do they take in high school?

A. Well, some of them have to learn to read and write. Mathematical skills which will help them in the budgeting. Knowledge of the community or a little history — things of this sort, depending on the individual's needs.

Q. Are there any ex-Pennhurst residents in this home?

A. Yes.

Q. How many?

A. Five.

* * *

* * *

Testimony of L. Stuart Brown

[10-104]BY MS. CHRISTENSEN:

Q. Mr. Brown, how are you presently employed?

A. I am the Executive Director of the Delaware County Association for Retarded Citizens.

Q. And what is the general purpose of the Delaware County Association?

You don't mind if I refer to it as DELARC, D-E-L-A-R-C?

A. Fine.

Q. What is the general purpose of DELARC?

A. The principal purpose is to promote the general welfare of all mentally-retarded citizens in Delaware County and to provide services wherever necessary for those who are in need of services.

[10-105] Q. Could you briefly relate how DELARC fits into the organizational structure of the Pennsylvania Association for Retarded Citizens and then the National Association for Retarded Children?

A. Yes. We are one of fifty-eight affiliated chapters of the State association and the State association is a member unit of our national association.

Q. How many members does DELARC have?

A. We have 825 families in membership presently.

Q. How long have you been executive director?

A. Thirteen months.

Q. How was it that you became involved with DELARC and got the position of executive director?

A. I have a retarded daughter and that generated an interest in mental retardation. I served as a volunteer with the Montgomery County association and the State association and with the national association and about a year ago I was laid off from my

job at GE and knew of the opening in the Delaware County association and applied for it and got the position.

Q. Have you also held other offices within the state association?

A. Yes. I have held numerous jobs as committee chairman and I am an immediate past president of the Pennsylvania association. I also have been a director of the national association.

Q. What are your responsibilities as executive director of DELARC?

[10-106]

A. The responsibilities as executive director cover a wide range from fund-raising activities for the administration of day-to-day operation of programs and services for the mentally-retarded; engaging in advocacy functions; being a spokesman for the mentally-retarded when that is necessary; counselling parents and promoting the needs of the mentally-retarded to the community, to the general public; engaging in promoting of activities toward research and the welfare of the mentally-retarded in general.

Q. Is DELARC involved in any ongoing programs for mentally-retarded persons?

A. Yes. We are working in conjunction with Elwyn Institute to provide a pre-school program for approximately thirty-six youngsters in the community and we are operating three sheltered work-activity centers serving approximately 170 mentally-retarded clients.

Q. Are you now involved in any community-living arrangement projects?

A. We are not presently involved in community-living projects directly.

We do have several proposals and we have run a community-living arrangement in Upland, just outside of Chester, for approximately five years.

That operation was spun off to another agency as of July 1, 1976.

[10-107] Q. Does the Association for Retarded Citizens on the national or the local level have a particular philosophy regarding the types of programs that it sponsors?

A. We have — we have a philosophy of obtaining services rather than providing the service and that we are teaching other agencies to run the service rather than provide the service ourselves.

However, in areas of need, where a vacuum exists, DARC has stepped in and provided programs.

* * *

[10-109] Q. Could you describe for me the general purposes of the work-activities center?

A. The purpose of our work-activity centers in Delaware County is to develop the individual's ability to perform useful tasks, work tasks, and to acclimate to the work-world, coming to work on time, sitting at the workbench, and performing the operations that we have asked them to perform.

Q. After the stage of the work-activity center what is the next stage on the continuum of the employment-field training?

A. When we see a client in our programs that we believe is capable of being more proficient and carrying greater responsibility, we refer them to our part-time psychologist and an evaluation is made of the individual.

The parents are then contacted and recommendations are made from DELARC suggesting that the client be enrolled into the Bureau of Vocational Rehabilitation program and moved up into a higher level of work opportunity.

Q. In the period of time in which you have been di-

[10-110] rector or deputy director of DELARC have increas-

ing clients been referred to the Bureau of Rehabilitation?

A. Yes, quite a few over the years. At one time the Bureau of Vocational Rehabilitation worked directly with DELARC.

In recent times they have held their funds only for those higher-functioning individuals. As a result, we have referred the individual to the BVR program that is sponsored by the Elwyn Institute and some fifty clients — I believe fifty was the figure — have gone through our workshop and entered into the BVR program.

Q. Do you know where they go thereafter, after they have gone through the BVR program?

A. We have, since 1956, been serving retarded persons in Delaware County. We have had 310 enter our workshop. Presently 170 are still there; 138 have graduated.

Some are unknown; at this point we have lost track. Some have been employed in various businesses. I have a few — Two Guys employed a couple of retarded persons out in Delaware County. There is one young fellow working in a car-wash; one fellow is working for ITE Circuit Breaker Company, and two are working for the Federal Government. — one in the IRS and one in HEW. Several are working in the post office and have been there over ten years of steady employment.

We have others who are working in Gimbels and Wanamakers and nursing homes scattered around the community.

Q. Are there any limitations on the number of persons who can go through this cycle? [10-111]

A. DELARC itself does not have limitations on people entering into or traveling through the cycle except for the fact that we limited ourselves to those who are ambulatory and who have a potential of working.

We do have one young lady who is legally blind. We have one young man on crutches.

But they are all ambulatory to the point where they can get about and perform work functions.

The waiting list for entry into the work-activity program is maintained by the base service units and not by DELARC.

Q. Do you know whether the base service units now have a waiting list for persons who are ready to enter into the work-activities center?

A. Those records are not accessible to us, but it is our opinion that they have people in the community who are in need of work services, who could fit into our program.

Q. How are these DELARC work-activity centers funded?

A. The Delaware County Association is funded through two sources: we do our own fund-raising to a certain extent through special events — bike hikes and other fund-raising opportunities that we have as an association.

The main portion of the funding that we receive comes from the County Mental Health-Mental
[10-112] Retardation Administrator.

Q. Is there a continuum for the workers?

A. Yes. This year for the first time we are on a *per-diem* work based on the average daily attendance of our clients in the work program; and this is since January 1st of this year.

Q. For the purposes of describing one program, could you tell me, are all three work-activity centers essentially similar? If we were to choose one and talk about it, would it be similar to the other?

A. Yes. All of our work-activity centers are similar with slight variations.

Q. Could you describe briefly how the Lansdowne program functions?

A. The Lansdowne program operates on the basis that we have staff and facility provided by the County Mental Health and Mental Retardation Administrator; and on our staff we have a contract procurement specialist, who contacts businesses in the area to bring work into the shop for our clients to perform.

Q. And that contract procurement specialist is on the DELARC staff?

A. Yes, he is.

Q. How do workers arrive at the center?

A. Most of our clients are transported in private automobiles, either through car-pools or through friends who drive them to the program.

[10-113] We do have about one-third of the work force who uses public transportation. All of our facilities are located along bus lines and are readily accessible through public transportation.

Q. What type of contracts are being performed now at the Lansdowne center?

A. We have a variety of contracts. At any one point in time we may have two or three running simultaneously.

One of the more consistent contracts has been with United Airlines, where we are refurbishing the headset that's used on the airlines to give you music and watch the movies.

When they are used they have to be refurbished and repackaged.

We are doing a lot of packaging and small assembly work for Creed Plumbing Supply Company.

We have a lot of plastic tableware — knives, forks, and spoons — produced by Unique Industries here in Philadelphia that we are packaging for marketing on the supermarkets.

There is a variety of small packaging operations for Southco Industries, for example, using Allen

tees, mounting the Allen tees on a ring and packaging them for sale.

Q. Could you tell me what wage this facility is paying for this contract work?

[10-114] A. We have a minimum wage that we guarantee to all of our employees, whether they are productive or not. Therefore, each one of our clients goes home with a paycheck.

But for those who are productive we watch their production and keep track of how productive they are and pay them according to their productivity.

Again, we do not exceed half of the minimum wage allowance established by Wage and Hour.

Q. Do the work-activity centers provide additional services or activities for the workers at each center?

A. There have been a variety of extracurricular activities. There are socials put on by the Optimists Club; dinners that the clients come to; the recreation area from the YMCA providing programs for off-duty hours for our clients; the base service units in a couple of areas have been providing subject socialization programs from time to time.

Q. Do you know generally where the workers from the activities center reside?

A. Most of our clients reside at home with parents. We do have a few who are living in foster-home placement and a few who live in community-living arrangements who participate in our program.

Q. To your knowledge have any former Pennhurst residents participated in DELARC's work-activities center?

[10-115] A. Yes, we have had several.

Q. Could you recount an example or two of former Pennhurst residents who have worked in one or the other the DELARC activities centers? I would ask you just to use a first name instead of Mr. So-and-so, so we won't mention any specific client's name.

A. All right. Yes, I can think of two. We have eighteen presently in our program who are former residents.

Mr. Robert has spent some time at Pennhurst; is now in our work-activity program at Upland. He was somewhat of a behavior problem when he came out: has settled down partly due to the forceful parent that he is living with and partly we believe due to the fact that he has a daily work-program in our facility.

He is doing very well in the work that is assigned to him and coming along very nicely in our program.

Q. Coming on very nicely? Does he demonstrate any particular work skills that he did not have when he first came to your work-activities center?

A. As I indicated, he was a little kind of a behavior problem, kind of resistive to being told what to do instead of sitting down and addressing himself to the job that he was given.

He has now acquired those skills. He seems to have changed in personality to the extent that he is not the behavior problem that he has been; that he
[10-116] does perform the job that he has been assigned, and it looks as though he will be eligible for the BVR program in the near future.

Q. Would you have another example of an ex-Pennhurst resident who is also in your program?

A. Yes. Mr. Joseph spent some thirty-five years at Pennhurst. He is working at our Lansdowne facility. He was very aloof and quiet and reserved. He separated himself from the rest of the workers when he first came a year or so ago and in the short time that I have known him as a worker in the shop where my office is he has come out of his shell. He is beginning to address himself to the clients — to

his fellow workers — and carrying on conversations with them and with supervisors that we have.

There is definitely a change in his personality. He is capable of riding a bus and he is living now with his sister and his nephew, who is also in our program, a Down's fellow, who is in the home with him.

Q. Would you say that these two examples are typical of the type of growth in social and employment skills that workers in your program exhibit?

A. Yes, I would think so. Most of the clients who have come into our program are just like any other people coming to a new job — a little bit apprehensive and nervous about the fact that they are in a work program.

[10-117] With a little bit of tender, loving care from our staff we have been able to convert those clients into the program and make them feel important as workers.

Q. In this change, are there problems as time goes on with these programs?

A. Nothing serious. We have had occasional seizures and most of the clients who do have seizures are controlled.

We do have occasionally one of our fellows on public transportation take the wrong bus and end in a community where he didn't expect to be, but he has not had any serious problems in that regard.

Q. These clients carry identification so that those who take public transportation don't find it too difficult to get back?

A. Yes, most of them do.

* * *

[10-141] BY MR. GILHOOL:

Q. Mr. Brown, you testified that in fiscal year 1975 Delaware County returned some $16,000 in community-living arrangements funds to the State.

I show you PARC Exhibit Number 58. Do you recognize that set of documents?

A. Yes.

Q. What is that?

A. That is the documentation of funding returned or carried over by the Mental-Health and Mental Retardation program in the Commonwealth of Pennsylvania.

Q. The first page reports the unspent and returned-to-the-state funds for fiscal 1975, does it not?

A. That's right.

[10-142] Q. And next to Delaware County it says $15,566 returned from CLA funds?

A. Yes, sir.

Q. And $619 returned in community-living arrangements coordinator funds; is that correct?

A. That's correct.

Q. What does the second page show?

A. This is for fiscal year '73-'74. It indicates that Delaware County returned or carried over $12,332 in CLA funds and $1,979 in community-living arrangements funds.

Q. Since Mr. Cotton inquired concerning Montgomery County, what does it show for Montgomery County for funds returned in fiscal 1974?

A. Base allocation, Montgomery County returned $181,000; and in community-living arrangements, $41,000; and CLA coordinator, $4,000, for a total of $226,000.

Q. And for fiscal year 1973, what does it show in returned funds for Delaware County?

A. In Delaware County, you are all the way across.

In Montgomery County, $19,459 in group homes and $3,325 in CLA coordinator funds.

Q. And for fiscal 1975, the year for which you testified as to Delaware County, what does PARC Exhibit 58 show for Montgomery County returns?

A. For base allocation, $260,774; in CLA funds,
[10-143] $79,869; in community-living arrangements funds, coordinator funds, zero.

Q. And the five-county total for returned funds in fiscal 1975?

A. $1,612,760 in base allocations; $350,961 in community-living arrangements; $601 in community-living arrangements coordinator, $8,179 in family resource service money; and $178,992 in developmental disabilities money.

Q. You testified under Mr. Watkins' examination that one of the reasons in your opinion that community services had not been provided for Pennhurst residents was the failure of the defendants to deploy the *per-diem* spending at the institution in the institutional budget for use in the community; is that right?

A. Yes, sir.

Q. What is the *per diem* expenditure on community-living arrangements?

A. I cannot give you a good answer for all of them, but for the facility that we operated in Delaware County for fourteen individuals it ran about $7,000 per year per client, and I really can't give you a quick figure.

Q. That would be about $20 a day if my math is correct?

A. Whatever my math works out to.

Q. You worked at General Electric. In addition to community-living arrangements which provide the
[10-144] residential facilities, there need also be, if a Pennhurst resident is to live in the community, some funds for programs and activities in the community as well; is that correct?

[10-144] A. That's correct.
Q. At your workshop, by way of example, and your workshop provides activity for adults, does it not?
A. That's right.
Q. At your workshop what is the *per diem* cost of those activities?
A. About $11, $11.50 presently. We were on a sliding *per diem* scale according to the number of clients authorized into our program and at present it is around eleven fifty.
Q. Around $20 per day per person for residents and what was your figure?
A. About $11.50 — $12.00 per day.
Q. For the activities program in the community?
A. Right.
Q. What is the *per diem* cost at Pennhurst?
A. The last figures I saw were in excess of $60 — $65, I believe.
Q. Now you testified in response to the Judge's questioning that all of the expenditures of community-living arrangements were borne by State funds, did you not?
A. Yes, sir, I did.
Q. And those are the expenditures which provide both for the leasing or the purchase of the residence
[10-145] and for its operation day-to-day, year-to-year; is that correct?
A. Yes, sir.
Q. And those costs are borne entirely by the State?
A. Yes.
Q. Now what about the program service cost?

You testified a moment ago that in addition to residence, if Pennhurst people are to live in the community programs and activities must also be supplied in the community.

Now how was the cost of such programs shared? Are they borne by the State? Are they borne by the County? Are they borne proportionately?
A. As far as I know, it is on a 90-10 county-State

funding stream for those services — ninety from the State and ten from the county.

Q. So that your workshop activities, for example, while you received that from the county, that is composed of $9 originating from the State and one dollar originating from the county budget?

A. That's right; yes.

BY THE COURT:

Q. Do I understand then that if more community facilities are provided and approved for your particular county it means that the county's cost is going to increase?

A. That's right; not for —

Q. By ten percent that may be necessary for the
[10-146] programs; is that correct?

A. That's right.

BY MR. GILHOOL:

Q. For the 132 people who once lived in Delaware County, who now live at Pennhurst, is it correct that the State pays one hundred percent of the cost of services to them?

A. That's right.

Q. That is to say, the State pays both one hundred percent of their room and board-residential costs at Pennhurst and the State also pays one hundred percent of whatever services or programs or activities are provided at Pennhurst?

A. As far as I know, that's right.

BY THE COURT:

Q. Are you saying that the State pays then the approximate figure of sixty dollar a day per resident?

A. That's right.

BY MR. GILHOOL:

Q. So that the county must contribute funds if a resident is to live in the county, but the county needs not contribute any funds if the resident lives at Pennhurst?

A. That's right.

* * *

[10-148]BY MR. GILHOOL:

Q. Mr. Brown, has the Delaware County Association for Retarded Citizens, at least until Mr. Watkins suggested it in his examination of you a bit earlier, ever considered it the responsibility or the obligation or the role of the Delaware County Association for Retarded Citizens to provide and to operate community residence for all of the 132 people from Delaware County who now reside at Pennhurst?

A. No. We have never considered operating facilities to accommodate that many people.

Q. Whose responsibility, in your view, is it to plan, provide, and operate such facilities for the 132 people?

[10-149] A. It is my opinion that the Government has the obligation and responsibility to all of its citizens to provide the backbone of services and that private providers such as the ARC should be modest — rather than providers of the services that should be provided by Government.

Q. Mr. Brown, you were state-wide president of the Association for Retarded Citizens in the years 1973 through 1975, were you not?

A. Yes, sir.

Q. And since the late 1960s until the present you have been an active member of the Pennsylvania Association's small executive committee, have you not?

A. That's right.

Q. Would you, ever so briefly, tell us, name for us, the committees of the State association which you have chaired since 1969?

MR. WATKINS: What's the purpose of this?

MR. GILHOOL: The purpose of this is to lay the basis for further testimony. It is to establish his knowledge and testimony.

MR. WATKINS: Expert testimony?

MR. GILHOOL: No, sir. It is to lay the basis for his factual testimony and hence to establish the basis for his knowledge of a certain fact, certain things that happened and have not happened since 1969.

BY MR. GILHOOL:

[10-150] Q. Would you please tell us what committees you have chaired in the Pennsylvania association?

A. Yes. In September of 1968 I chaired the Education Committee for the State association. In 1969, I think about May or June, I was chairman of the Legislative Affairs Committee.

Q. And for what period of time, beginning in May or June of 1969; were you chairman of the Legislative Affairs Committee or PARC?

A. From May of '69 through to, I guess, the end of June in '72; somewhere in that vicinity.

I also chaired the Legal Action Committee on the right to education and various other organizational committees like Personnel during the time that I was involved and a member of the Executive Committee.

Q. In the course of your work then as chairman of those committees, as a member of PARC's Executive Committee, and the president for two years and the first vice-president in the preceding years, did you have occasion to participate in the effort to replace Pennhurst with community services?

A. Yes. In 1969 the association took on a much more militant approach towards the State care and we felt that we could move things much faster if we were to get into litigation in behalf of the mentally-retarded.

[10-151] One thing that we did pick up shortly after I became the chairman of the Legislative Affairs Committee was the capital budget projection in the Office of Mental Retardation for the ten-year period from 1969 to 1979.

We made an analysis of that proposal wherein it was intended to spend $17 million, $16.8 million, to fix up, to dress up, the old buildings at Pennhurst, build a new education building and a new administration building; and we looked at that $17 million as being a very large figure and we had to put it into something that had a meaning for us.

At that time you could buy a new home in my area of Montgomery County for about $28,000, and dividing $28,000 into $17 million, we could buy 607 houses.

If we took four residents from Pennhurst and put them in a house, a nice family setting, the whole 1900 residents at Pennhurst at that time would have been accommodated in 475 houses for an expenditure of about $13 million.

With the $4 million that was left over we could have bought $8,400 worth of furnishings for each one of the 475 homes.

With this analysis we apprroached the Legislature, talked to Senator Frame, had him amend a bill that he had introduced for the General State Authority, a multi-million dollar appropriations bill, in the area of Pennhurst, indicating that within the next years 900 residents were to be removed from
[10-152] Pennhurst and provided with a community-living arrangement and supportive services in the Southeast Region.

Q. And you participated closely in the negotiations which led to that piece of legislation?

A. Along with others in our association, yes.

Q. What happened thereafter?

A. Well, the State then took about six or seven months to hire in a man to develop the plan, how they were going to disperse 900 people from Pennhurst, and where those individuals would go.

Dr. Floyd McDowell made the plan, which now is GSA Project 523-1, Phase I, and took the records

of individuals, determined that they would need suitable different types of living arrangements to accommodate all of those 900 people; and indicated roughly where those people would be housed in the Southeast Region.

Q. Is this the report to which you have reference?

A. Yes, it is.

Q. This is the McDowell report?

A. Yes.

Q. Page one of the Act II sheet?

A. Yes, it was.

Q. And this record was completed by the 24th of March of 1971?

A. In that time frame, yes. I couldn't give you the exact date.

[10-153] MR. GILHOOL: It is, for the record, PARC Exhibit Number 24.

BY THE COURT:

Q. Who is Mr. McDowell, do you know?

A. Dr. Philip McDowell was hired by the Office of Mental Retardation.

Q. Of the State of Pennsylvania?

A. Yes, to develop this plan in their behalf. Other than that I am not sure of his credentials.

BY MR. GILHOOL:

Q. You testified, Mr. Brown, that in this report Mr. McDowell designed ten types of living arrangements for retarded people?

A. Nine or ten, whatever the figure was; that's right.

Q. Ten. Then he assigned all of the Pennhurst population to one or another of those nine types of living arrangements?

A. The 900 that he was considering. He was only looking at 900 individuals to move into the community and he developed those ten different types of homes for the very mild, almost independent-living

group, to the severly-retarded and medically-dependent individual.

Q. So that among them those nine types would accommodate the full range of disabilities represented in the Pennhurst population?

A. I would think so.

Q. And those nine types designed by Dr. McDowell
[10-154] became the basis for the seven or eight types of community-living arrangements under the Community-living Arrangements Program, did they not?

A. That's true.

Q. Now in addition to describing and costing the residential facilities for the 959 Pennhurst residents, the report also designed and costed service facilities as well, program and activity facilities, did it not?

A. That's right.

Q. And in addition it also identified what type of living arrangements would be necessary for the then additional 1,000 people who lived at Pennhurst, although it did not site them; is that correct?

A. That's true.

* * *

[10-155]BY MR. GILHOOL:

Q. This report finally also identifies the type of living arrangements for the then over 2,000 persons on the waiting list for Pennhurst, does it not?

A. Yes, it did.

Q. Now Mr. Watkins asked how long it would take you to prepare a plan and propose it for community-living arrangements and services in the community with 132 residents of Pennhurst who originated in Delaware County.

Your answer was a month, I believe?

A. That's right.

* * *

BY MR. GILHOOL:

Q. Is it fair to say, is it the case, Mr. Brown, that one of the reasons why you could prepare such a full set of plans and proposals for replacing Pennhurst in the lives of those 132 with services in the community — is it fair to say that one of the reasons that you could do that so quickly is because Dr.
[10-156] McDowell, in his Phase I report, did it for you fully six years ago?

A. Certainly. We would use the McDowell report as a base for the types of group homes.

I would also use the proposals that we already have where much of it is boilerplate requirement according to the guidelines and the program in that area just follows the difference in proposals generally, the differences in proposals generally is insignificant.

MR. GILHOOL: Thank you, Mr. Brown.

THE WITNESS: One further thing. I was talking about the community-living arrangements and not a full array of programs when I answered Mr. Watkins.

* * *

Testimony of Magdalen Bolin

[10-160] MR. RIVERA: The United States calls Magdalen Bolin.

MAGDALEN BOLIN, having been duly sworn, was examined and testified as follows:

BY MR. RIVERA:

Q. Where are you currently employed?

A. I am employed at Ken-Crest Center at 6224 Wissahickon Avenue, Philadelphia.

Q. And what position do you hold?

A. Residential program supervisor.

Q. And what are your duties as residential program supervisor?

A. I am responsible for the overall management of the house programming for the residents, training and supervision of the relief staff, and the physical operation of the house.

Q. Is that house at 6224 Wissahickon — is that the way you pronounce it?

A. That's right.

Q. — a community alternative home for mentally-retarded citizens?

A. Yes.

Q. Is there a name under which the home is known?

A. No.

Q. Is there a reason why this home doesn't have a name?

A. Because most community houses don't have names.

[10-161] Q. How many people live in this home?

A. Six boys and my husband and myself.

Q. What are the age ranges of these boys?

A. From nine to seventeen.

Q. Could you describe the type of neighborhood in which the house is located?

A. It is in the Roxborough section of Philadelphia, an old residential area. We live across the street from a park.

Q. I now hand you United States Exhibit 48, Pennhurst State School and Hospital photographs, and ask you to turn to page thirty-eight, pictures 73 and 74, and ask you whether that's an accurate representation of the house at 6224 Wissahickon Avenue.

A. Yes.

[10-162] * * *

BY MR. RIVERA:

Q. Looking at pictures 73 and 74, could you walk us through the house?

A. Okay. In 73, the house is a three-story duplex. It is on the corner of the street. You walk into the living room. The living room has a sofa, chairs, bench, aquarium, television, stereo; lots of plants, and a desk.

We have the kitchen behind that and the dining area behind that and a bathroom after the dining area.

The second floor has three bedrooms and a bathroom. Each of the bedrooms has a bed and each of the guys has his own dresser and mirror. They put their things in the room.

Each of the guys has either a television or stereo; book shelves, clock-radios — pretty much what you would see in any house.

Q. Is the whole duplex used? Do you occupy the whole duplex or just part of it?

A. We live on the left side of it.

[10-163] Q. Who lives on the right side of it?

A. A young woman.

Q. Is there a specific purpose for this house besides to live in?

A. It is to teach them to be able to cope with the living community.

Q. What would be known as an interim facility?

A. No, it is not.

Q. Is there a name for a group home?

A. It is a long-term sheltered children program.

Q. Are there any community support services available for the youngster?

A. Yes.

Q. What type?

A. We have the use of the local base service unit, which provides monthly program evaluations for the guys. It has provided individual counseling for the guys.

It has provided staff training for us, especially dealing with the emotional difficulties that the residents might have. We use the community guide services, of the dentist, local hospital, local speech therapist, and things of that nature.

Q. Do you offer a different type of program within the house?

A. Yes.

Q. What type of program?

[10-164] A. We have specific programs available which give the guys real preparation — housekeeping skills, laundry skills, self-care skills, sexual awareness — things pretty much which, you know, the things that they want in the community.

THE COURT: Let me interrupt you.

BY THE COURT:

Q. How old are they?

A. Nine to seventeen. We have one 9, one 14, three 15, and one 17.

Q. All boys?

A. Yes.

Q. You call them guys?

A. I call them guys.

Q. Do they like that?

A. Yes. The teenagers don't like to be called kids.

THE COURT: Guys? Okay.

BY MR. RIVERA:

Q. Are all the residents in some type of educational—

THE COURT: By the same token, do they call the girls dolls?

MR. RIVERA. I think that's the next witness, your Honor.

THE COURT: All right.

BY MR. RIVERA:

Q. Are all the residents in some type of educational program?

[10-165] A. Yes.

Q. What type of educational program are they in?

A. Four of them attend the high school, which is a special center for the training of the mentally-retarded students.

One of them attends Cook-Wissahickon School, which is a public school, which has special classes in K-8, and one of them attends Shawmont School, which is the same kind of a situation.

Q. How do they get to school?

A. Five of them go by school bus and one of them takes public transportation. He takes the SEPTA bus and then he makes a transfer and takes another SEPTA bus.

Q. Has he ever been lost?

A. No.

BY THE COURT:

Q. How is he getting to school these days?

A. By whoever is available to pick him up and take him.

BY MR. RIVERA:

Q. Do you have any ex-Pennhurst residents?

A. Yes.

Q. How many?
A. Two.
Q. Using just their first names could you describe them in terms of skill when they first arrived at the home?
A. Okay. Mr. Mario is now fifteen. He was twelve
[10-166] when he came to the house. He is still non-verbal.

When he came in he had severe behavior problems. He would do such things as eat newspapers and he would be ———. He would do these things also at school and we had several notes from the teacher that his behavior was uncontrollable and intolerable.

He had daily tantrums. He was biting or hitting and biting the kids, breaking furniture. He defecated in his pants and in his bed quite regularly.

You know, that's pretty much the major things.
Q. Did he experience any growth —
A. Yes.
Q. — while living at your home?
A. Yes.
Q. Could you describe in which ways he has grown and developed?
A. Well, he no longer defecates in his pants. His last report from school indicates that he was a model student, extremely cooperative.

He interacts with the other residents and the staff and the neighbors very well, even though he is non-verbal yet.

His school education has really improved. He is in a speech program at the house and he is beginning to communicate further.

[10-167] Q. Is that all?
A. Yes.
Q. What about the other ex-Pennhurst-resident?
A. That's Mr. Chris. He has the same kind of problem.

His behavior was quite a problem. He was very obstraperous around the house. In school he had frequent tantrums outside the house, using very loud obscenities. He messed his pants frequently. He ate the after he used them, and those were some of the major ones.

Q. Has he grown and developed?

A. Yes.

Q. Would you tell me in which ways?

A. In social skills, ability to communicate with other people. He doesn't have tantrums. He may use obscenities in the privacy of his room but not when other people are around.

That's pretty much it.

Q. Speaking of Mr. Mario, would you walk us through a typical day of his life?

A. He gets up around seven o'clock. He wakes himself up using an alarm clock. He gets up, makes his bed, gets dressed, using the bathroom, shaves, —

Q. How old is he?

A. Fifteen.

Q. And he shaves?

A. Well, he doesn't shave much but he likes to do it.

[10-168] And then, after he goes down and he makes himself breakfast; and depending on what he is having we might have to help him.

Q. Does everybody make their own individual breakfast?

A. They all do, yes. If they need assistance, if they are having something like eggs or bacon or something like that, —

Q. Is there one standard menu for all of the guys or do they all have different things at breakfast?

A. They all have what they want.

Then, after breakfast, he cleans up, puts the dishes in the dishwasher, and tries to get ready to go. He brushes his teeth and tries to get ready to go to school.

Q. Then he goes to school?

A. He goes to school, gets on the bus at twenty to nine.

He comes home from school at twenty to three. Then he changes into jeans, kind of does the laundry or whatever needs to be done around the house.

He might go outside to take a walk, go over to the park, play baseball, basketball.

And then help with the dinner, eat dinner. Then, after dinner, sometimes we go to the malls or something like that.

He does his speech program homework and then gets a shower and goes to bed somewhere between ten and eleven.

Q. Is this a typical day that the other children would be going through?

[10-169]

A. Pretty much typical. Each person pursues their own interests.

THE COURT: Let me just interrupt to ask a question.

BY THE COURT:

Q. The last young man that you talked about, the last guy you talked about, where was he before he came to your home?

A. Both of these two came from Pennhurst.

THE COURT: I believe you said that.

BY MR. RIVERA:

Q. Does Mario's schedule change on the weekends?

A. Yes. He doesn't go to school. We generally take — we generally are more active and we go to the Franklin Institute, movies, the Phillies game, up to the Poconos, the State park, climb fire towers, go in restaurants — pretty much what other people do.

Q. Who decides what to do on weekends?
A. Generally they decide what they want to do.

* * *

0-170] BY THE COURT:
Q. How are the costs of this community home provided, if you know?
A. It is through the State. The money goes through the County and then the County gets —
MR. SACHS: Louder please.
THE WITNESS: The money comes from the County, channeled through the County, I think, and I think the County disburses it to us.

BY THE COURT:
Q. How, as I take it, are you an employee, therefore, of the State?
A. No. I am an employee of Ken-Crest.
Q. Ken-Crest?
A. Yes, sir.
Q. Now tell me again. You did say that in the beginning, but who is Ken-Crest?
A. Ken-Crest is a non-profit organization serving mentally-retarded people and their families. They have a lot of other programs too.
Q. Do they have a lot of other programs in Philadelphia?
A. Yes.
Q. And how about in the other counties, if you know?
A. Yes.
Q. For instance, do they have a program in Chester
10-171] County, if you know?
A. Yes, they do have one.
Q. Montgomery?

A. They have three in Montgomery County and two due to open in a month.
Q. How about Bucks?
A. None in Bucks.
Q. None in Bucks?

And how long have you been employed by Ken-Crest — is it Ken, K-e-n?
A. Yes.
Q. How long have you been employed by them?
A. Almost six years.
Q. Six years?

And did I understand you to say you live there with your husband?
A. Yes.
Q. Is he also an employee?
A. He is a part-time employee. He has another job.
Q. Your husband has another job.

What does your husband do, by the way?
A. He is the director of a vocational rehabilitation program in Roxborough for young retarded adults, serving severely and profound mentally-impaired.
Q. And who employs him?
[10-172] A. He is employed by Intercommunity Action, Incorporated, which is our local base service unit.

THE COURT: All right.

MR. FERLEGER: I have a couple of questions, Judge.

CROSS EXAMINATION

BY MR. FERLEGER:

Q. When you need relief for taking care of the guys, what do you do?
A. We have four part-time staff people who cover for us.
Q. Do you like your work?
A. Yes.
Q. Why?
A. Because I like — I see a lot of progress in the

guys and I think it is very good for them to live and it is good for me too.

Q. Did you ever work in an institution like Pennhurst?

A. I haven't worked at Pennhurst but I worked for a short while at Ken-Crest Residential Center in Mont Clare.

Q. And is this sort of program you are working in now more satisfying to you as a worker?

A. Yes.

BY THE COURT:

Q. Let me just ask you, what is your educational background?

A. I have a Bachelor's degree in History from Temple University and I have had a minor in Psychology and some graduate experience in Social Administration.

[10-173]

* * *

BY MR. LASKI:

Q. When you described the behavior of the residents of your home who came from Pennhurst, you said that they exhibited abusive behavior or intolerable behavior, got reports from the schoolteacher and so forth, and eventually they made progress to where their behaviors were quite good.

Could you describe to the Court what types of programs and what types of efforts and activities you engaged in to bring about this growth in development and behavior?

A. Basically, the attitude of expectation, and I find that people generally come up to the expectations that you have of them.

The guys all like to live in the community, they all like living in a group home.

They really didn't like living at Pennhurst and I think that they were eager, willing, and ready to

change and we provided an atmosphere for them to change; and they did.

[10-174] This is a program that we all believe in the philosophy of normalization and treat the guys like kings and when we treat them like kings we find that they act that way.

MR. LASKI: Fine.

BY THE COURT:

Q. What did you say to these teenagers that would, as you say, mess in their pants?

A. We really didn't say anything. We found it is much better to praise them when they do good things than to punish them.

Q. Is it your testimony, therefore, that they learned to adapt to their surroundings and didn't do that anymore?

A. True.

Q. How long did that take?

A. With one of the guys it took about six months; and with the other guy it took about a month.

THE COURT: All right.

Thank you.

* * *

Supreme Court, U.S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

**ON WRITS OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

JOINT APPENDIX
VOLUME IV, A695-A812

**Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.**

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

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**Qualifications of expert witnesses were stipulated pre-trial, Curriculum vitae designated as PARC and US Exhibits, detailing education, experience, publications and other qualifications of all plaintiffs' witnesses are found in the Final Pre-Trial Order filed at R. 464, March 31, 1978.

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Testimony of Jeanne Hight

[11-15] MRS. JEANNE HIGHT, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. STUTMAN:

Q. Mrs. Hight, you are the mother of a retarded child?

A. Yes, I am.

Q. And what is your child's name?

A. Robert.

Q. And he is one of how many children?

A. Seven.

Q. And what is the age range of your children?

A. On to Robert is 12.

[11-16] Q. Is he the baby?

A. Yes, he is.

Q. When was he born?

A. June 7, '65.

Q. Was he retarded at birth?

A. No, he wasn't. He had encephalitis.

Q. At what age?

A. 11 months.

Q. And as a result of that illness is he now disabled?

A. Yes, he is. He is severely disabled and paralyzed on his left side.

* * *

[11-17] Q. When was the first time you sought the assistance of the County Mental Health and Mental Retardation Administration?

A. In 1970 we were told by Dr. Gelman to look for some place to put him; and I went to the Mental Health Unit to put him on the list for Pennhurst because that was the only alternative I had.

Q. In which county did you reside in 1965?

A. Delaware County.

Q. Do you still reside in Delaware County?
A. Yes, I do.
Q. When you sought the assistance of the County authorities, what place did you go to?
A. We went out to Media, to the Mental Health.
Q. At that time in 1970 what were your expectations for your child, Robert? What did you expect he was capable of learning and doing?
A. Well, from what I was told by the doctors, he would never get any better but, of course, I never gave up hope.
Q. In 1970 you said you went to Media.

What did you do in Media besides put him on the waiting list?
A. That was all. We put him on the waiting list because I didn't want to leave him with my other children. It was just like taking out insurance.
[11-18]
Q. Were you concerned about the future in the absence of both you and your husband?
A. Yes.
Q. At that time were you advised by anyone in the County Office that there was a community program which could reach or meet Robert's needs?

MR. WATKINS: Your Honor, may I ask that the witness not be led throughout the entire testimony?

MR. STUTMAN: I will withdraw the question.

BY MR. STUTMAN:

Q. Did you know of any community alternatives at that time?
A. No, I didn't. I don't think there were any.
Q. Was Robert in school between 1965 and 1970?
A. No, he wasn't.
Q. When he became five years old did you try to enroll him in the public schools?
A. There were no schools that would accept the child as severely handicapped as he was.

Q. What was the date on which Robert ultimately entered Pennhurst?
A. Pennhurst?
Q. Yes.
A. That was three years ago. He went in —
Q. Might I refresh your recollection by suggesting it was in September of 1974?
[11-19] A. Yes.
Q. Does that sound about right?
A. Yes, it was.
Q. Between 1970 and 1974 where did Robert reside?
A. At home.
Q. During that time did you have any contacts with either the County office in Delaware County for mental health and mental retardation or your local base service unit?
A. No, I did not. No.
Q. During that time did the County office or the local base service unit provide you with any respite care?
A. No, none at all.
Q. Did they provide you with any other kinds of support services which would have been useful?
A. No.
Q. What happened in 1974, if anything, which intensified your needs for some assistance with Robert?
A. Well, my husband had a heart attack.
Q. And when was that?
A. That was in February, '74.
Q. And how did that complicate the home situation for you and your family?
A. Well, he was disabled. I had him to take care of plus five other children living at home; and it was impossible.
[11-20] Q. How did Robert get around the home?
A. He crawled.

Q. After your husband became ill did you take any steps to gain assistance from any County office or base service unit for your family?

A. Well, there weren't any services that would do me any good.

Q. There was a hearing, wasn't there?

A. Yes, yes.

Q. At that hearing who attended besides yourself and your husband?

A. There were two people from the base service unit.

Q. Do you recall who they were?

A. Larry Kashi and Mrs. Moffa.

MR. WATKINS: Can we learn when that was?

BY MR. STUTMAN:

Q. That was in August of 1974?

A. Yes.

* * *

[11-21] BY MR. STUTMAN:

Q. At the hearing do you recall any discussion about where Robert could reside other than at Pennhurst?

A. Well, there was no other places available. They were all filled up.

Q. Do you recall the day when Robert went to Pennhurst.

[11-22] A. Yes, very well.

Q. Could you describe that day?

A. Well, we took him up, my husband and I and my daughter, and he was put in a unit. I don't recall the number of it.

There were about 45 other children in it.

Q. Had you been to Pennhurst before?

A. We had been once before.

Q. And did you have a tour?

A. Not exactly. They showed us just like the dining area, where they would eat.

Q. When was the next time you saw Robert following his placement at Pennhurst?
A. Two and a half weeks later.
Q. What was the purpose of your visit to Pennhurst?
A. We went up on a Saturday morning to bring him home for the weekend.
Q. Could you describe Robert's physical appearance at that time?
A. Well, he was black-and-blue. There was a black-and-blue on his back. His mouth was all cut and he was heavily drugged. He didn't know me.
Q. Did you take him home for the visit as planned?
A. Yes, we did.
Q. Did you bring Robert back to Pennhurst?
A. No, I never did. He is still home.
[11-23] Q. So he was at Pennhurst a total of two and a half weeks?
A. Yes.
Q. When you were picking up Robert that day did you observe anything about the ward itself?
A. Well, there were approximately 25 children walking around naked and there were others that were partially dressed.
Q. Why didn't you bring Robert back to Pennhurst?
A. Well, my conscience would bother me.
Q. In what way?
A. I wouldn't leave a dog in conditions like that.
Q. You mentioned that Robert was heavily drugged.

Can you describe what indicated that to you?
A. Well, he could crawl before and he couldn't. This is two and a half weeks later.

He couldn't sit up. He couldn't hold his head up, and I took him to the doctor because of the bruises on his body.

It took at least a week for the drug to wear off that he could even sit.

Q. Was he able to do, after you took him home, the things that he could do prior to your putting him in?
A. No, he couldn't.
Q. Robert is presently at home?
A. Yes, he is.
Q. What kind of things would you need from the
[11-24] County and the base service unit to support you and your family in raising Robert?
A. Well, an occasional babysitter. My husband and I never go on vacation. We never go out. It is impossible; we can't.
Q. Have you had occasion to ask for a babysitter recently?
A. My grandson made his first communion two weeks ago and I called them for a babysitter.
Q. Whom did you call?
A. Larry Kashi.
Q. Is he in the base service unit?
A. Yes, he is.
Q. And what were you told?
A. That service is no longer available.
Q. Have they provided you with any visiting nurses or services?
A. No, no.
Q. Any homemaker services?
A. No.
Q. What is Robert's present status with reference to Pennhurst?
A. He is on a three-year leave of absence.
Q. Do you know what that means?
A. It will be up in September.
Q. What does that mean?
A. That means he either goes back or he has to re-
[11-25] port to me again.
Q. In other words, within three years Robert can go back to Pennhurst at any time?
A. At any time, yes.

Q. At the expiration of three years he is taken off the waiting list?
A. Yes.
Q. Taken off the roll?
A. Yes.
Q. What kind of services would you want in Delaware County for Robert?
A. I would like a place in the community that would be close and equipped to take care of a child like him.
Q. A community residence?
A. Yes, or he could live at home if I had some help.
Q. Could you describe the type of help you would need to have Robert living home with your family?
A. Well, just as I said, I would have liked to have gone to my grandson's first communion but I didn't.

* * *

[11-80] **Testimony of R. Kulp**

* * *

A. He went to the apartment cluster first.
Q. Can you describe any growth or any changes that you observed and are aware of in Wayne during this period of time that he has been at the apartment cluster?
A. We worked on socialization, his money-management and budgeting concepts, his banking skills; also, his maintenance and personal hygiene, his dress, his mannerisms, also enabling him to continue in his employment.

He has also been going to night school, taken a couple of courses in elementary mechanics offered at the night school, besides academic areas.

He is presently taking — he has a learner's permit and is getting ready to take his driver's examination and he is also preparing right now to move out of our program into an independent apartment structure with three of the other men or two of the other men in the program.
Q. Do you know how long Wayne was at Pennhurst?
A. 17 years.
Q. Do you have any other examples of any other residents living in the apartment cluster from Pennhurst?
A. We have had another fellow named Russell, who has done reasonably well too at the program. He is doing many of the similar things that Wayne had learned in the areas of socialization, money-management, preparation of food.

Also, you know, the making up of shopping lists
[11-81] and purchasing of the various items.

He has also participated in our programs in survival skills; also gone to evening school and secured

a job at the Holiday Inn, which he has held for about the last 18 months.

He has done real well. He works as a night janitor there.

Q. How long was Russell in Pennhurst?

A. 35 years.

Q. And the type of skills that you described, are these skills that he had when he came out of Pennhurst?

A. No, he did not.

* * *

Testimony of Ronald W. Conley

* * *

[11-93] MR. LASKI: Your Honor, Dr. Conley is qualified as an expert in the economies of services to the mentally-retarded, the sociology of mental retardation, the economic and political determinants of public policy and services for the retarded, and planning evaluation, social welfare and human services programs in the United States.

DIRECT EXAMINATION

BY MR. LASKI:

Q. Dr. Conley, did you undertake a complete study of the economics of services to the mentally-retarded?

A. Yes.

* * *

[11-95] Q. What were your findings in respect to your analyses of the several epidemiological surveys of mental retardation and demographic characteristics of mentally-retarded persons?

A. In looking at the epidemiological studies that existed at the time, the one thing that was very striking is that none of them agreed with each other.

* * *

[11-96] When one begins to adjust for all of these various factors one could begin to develop considerable amounts of agreement among the various studies and, in fact, ultimately I concluded that the estimate of mental retardation was about three percent in the population, which was, surprisingly, the figure that had been used for a very long period of time.

This comes out to about 5.6 million people, of whom the vast majority were what were called mentally-retarded and IQs say between 50 and 70, the vast majority, by 88.2 percent.

Another 8.3 percent were what were normally regarded as moderate; and severe retardation with an IQ under 50, and the remainder or a very small percentage were profoundly retarded with an IQ of below 25.

* * *

[11-97] I think it should also be pointed out that this estimate is the summation of many separate prevalent rates. For example, we found much higher rates of mental retardation among the poor and the Whites and the three-percent figure is sort of the weighted average of these various prevalent grades.

Q. What did you find in terms of the numbers of people of that 5.6 million who are in institutions throughout the country?

A. The majority of mentally-retarded, of course, live in the community and they always have lived in the community.

Of the 5.6 million we estimated that in 1970 only about 270,000 were in some sort of full-time residential care. The majority, about 186,000, in public institutions for the mentally-retarded, such as Pennhurst.

This is based on data that we were able to accumulate from the American Association of Mental Deficiency, which did a survey that year on the institutional population; information from the National Institute of Mental Health, which conducted a survey for that year; plus information from the massive facility inventory from the National Center for Health statis . . .

* * *

[11-98] Q. Dr. Conley, given that most mentally-retarded persons do live in the community and have lived in the community and only a few are in institutions, can you explain why persons are placed in institutions such as Pennhurst?

A. Up until again very recent years most parents really had only two alternatives. The most retarded person had really only two alternatives.

Either the person could remain at home with their parents —

I take it back. Make it three alternatives.

If they were a child they could remain at home with the parents. If they were an adult they could

[11-99] somehow live independently or they could go into institutions which provided basically full-time total care.

There was not the range of alternative-care facilities that were desperately needed in the community. Lacking these alternative facilities that provided lesser degrees of supervision than a public institution, if they could not be kept at home, then, indeed, they would have to be placed in an institution and there were many, many circumstances that would arise that would prevent a retarded person from being kept at home.

In those days, lacking adequate public or community services for the retarded, parents would have no relief from what would amount to daily, 24-hour-a-day, constant attention that would have to be paid to children.

If the family lacked its own resources to get adequate services, lacking respite care with other children in the family, then frequently an institution seemed to be the only way to obtain relief.

This was made apparent from the fact that of the retarded persons in institutions in 1970 —

THE COURT: Could I interrupt and ask you a question?

BY THE COURT:

Q. I am not sure that you gave me the number. How many retarded did you estimate were in institutions in 1970?

A. 270,000.

[11-100] Q. 270,000?

A. Right.

Now let me qualify that — 270,000 in residential care, of which about 186,000 were in public institutions for the retarded; another 30,000 were placed in public mental hospitals; and say another 30,000 from private institutions for the retarded.

And then a small number placed in other types of facilities, and we even include the few thousand in prison because in some parts of the country that seems to be one way of institutionalizing the retarded.

Q. Dr. Conley, did you have any figures which would indicate what percentage of retarded persons at each level of development were in institutions and what percentage were living in the community?

A. Yes. In 1970 we estimated that one third of the profoundly-retarded, one fifth of the moderately-to-severely-retarded, and only one fiftieth or two percent of the mildly-retarded had to be placed in institutions.

Q. Is it your testimony that one third of the profoundly-retarded were in institutions and two thirds were living in the community?

A. Yes.

* * *

[11-103] BY MR. LASKI:

Q. Dr. Conley, what type of services does a mentally-retarded person need?

A. The mentally-retarded basically need the same types of services that anyone else needs and they basically have the same goal.

In providing services one wishes to develop their intellectual skills, their physical skills, their cultural and their vocational skills.

The only difference that one finds between the mentally-retarded and a so-called non-retarded person is that the mentally-retarded may take additional services. They may take them in somewhat modified form. Their development may be somewhat slower and a little less complete than those of other individuals; and of adults; those who are more severely retarded will certainly need some form of supportive care, and by "supportive care" let me emphasize I don't necessarily mean 24-hour-a-day care, but some degree of support.

[11-104]

Q. Do the retarded require that these services be provided separately and away from other services to the general population?

A. Let's again take a quick view as to what services we are talking about because they require, as I said before, the same things that anyone else requires. They need to be educated they need to be provided medical care, they will need counseling and as adults they may need some modification of the work and cultural environment in order to function properly.

For the most part these services can be provided in the same setting as for anyone else. You know, in education, we have special education classes in the public schools and for those who are less severely retarded, with special help, they can frequently be integrated right into the classroom. Medical Care, there is almost no classification for providing it separately from a non-retarded person.

Work, the vast majority of mentally-retarded do work in what I call regular employment settings.

[11-105]

In fact, setting up separate services for the mentally-retarded can be very expensive, prohibitively expensive, in fact.

Can you imagine setting up an institution serving 1200 or 1500 persons, a medical facility of the type of quality that one can find in a major city like Philadelphia? It simply can't be done.

Q. But are there not economies of scale in large-scale institutions for the mentally-retarded?

A. Economies of scale is a very difficult term to justify when one really begins to look at institutional care.

To begin with, caring for the mentally-retarded in institutions is what we call a labor-intensive industry. It takes people and people can only serve so many people and once you get beyond serving a certain number of people you are going to increase staff at the same rate that you increase the resident population, which means that there will be very few economies of scale. Costs will increase roughly in proportion to population.

As a matter of fact, it is my belief that in many institutions there are very substantial diseconomies of scale because if you look in institutions that are placed, as many of them are, out in the country and one attempts to make self-contained units out of
[11-106] them, they are institutions that have their own water supply, their own power supply, their own mortuary, their own cemeteries, their own medical facilities.

They are providing these things on a very small scale and relative to the cost of getting these same services in an urban environment, as we all know, the water bill is a flat rate, what has to be paid for in an institution is very expensive. In other words, it is like a very small city; it is extremely inefficient.

Empirically, I looked in 1970 at about 150 residential facilities, that is, 150 institutions, which was the vast majority in the country of any size; and based on digress analysis and scatter diagrams I be-

gan to compare population sizes and costs and found that there were almost no economies of scale once the resident population got over 500. Now that was empirical work and that empirical work is very suspect because economies of scale probably don't exist up to that size.

For example, in looking at residential facilities as a unit, as we did, we assume that the same type of services were appropriate for all the residents of that facility, which is manifestly untrue. A mildly-retarded person who requires some type of supervision can live in the community with far fewer services than institutions provide and economies of scale for this type of retarded person would be far smaller. It would be a much smaller facility that would be appropriate.

One should also consider another factor, that in
[11-107] addition to looking at costs one should always look at the quality of care, and large institutions frequently have low costs because the quality of care that is provided is often very low. Residents are crowded into wards, relatively few developmental services are provided, and looking at these facilities on the basis of cost alone, without looking at the quality of care that is provided, it is very expensive.

Q. Even if there were some economies of scale, are there some compensating advantages to small-scale residential facilities in the community?

A. I believe that there are a number of reasons why there may be major advantages to having community facilities for the mentally-retarded.

To begin with, I think there are several reasons why one would have lower costs. One relates to this notion of economies of scale.

If you put facilities in the community then the facilities can purchase services at community rate. They can purchase water at the regular rates of the

water company. They can purchase power at the regular rates of the power company. They purchase medical care from the local hospital and all of these various services that the facility will obtain should be considerably cheaper than that provided in an institution.

The second reason why small facilities in the community should be less expensive than large
[11-108] residential facilities is that small facilities curtail the services to meet the needs of a particular group of the mentally-retarded. Take a large facility like Pennhurst. It basically is limited to providing 24-hour-a-day care —

* * *

THE WITNESS: In terms of lower costs, given that public institutions in general provide 24-hour-a-day care, total care, small facilities which are the
[11-109] alternative can be specialized where you only provide that amount of care needed for specific groups of the mentally-retarded; and to provide only that amount of care, the cost of providing services should be very much less.

The second and very important point is that in addition to lower costs, there are substantial benefits to placing the mentally-retarded in the community rather than in a large institution.

For one thing, placing the retarded in community-living arrangements makes it possible to keep the mentally-retarded closer to home and maintaining community ties is considered very beneficial.

Even more important, placing the mentally-retarded in the community makes it possible for them to seek and obtain employment, employment that can be very remunerative and rewarding both to the mentally-retarded and to Society.

I concluded in 1970 that the economic argument in favor of small community-based living ar-

rangements for the retarded were very strong and that the social benefits to Society would be very great.

At that time I thought they would be as high as $8,000 per person, considering what you would save in terms of rationed institutional costs and what the retarded would be likely to earn in the community. Since then the potential gains have increased remarkably.

[11-110] Q. You mentioned one benefit of small-scale facilities in the community is the ability to locate work in the community settings.

Do your studies indicate that retarded people have work skills and are capable of employment?
A. One of the surprising things that came out of the work that I did was that we concluded that the mentally-retarded have very strong vocational potential. I think then and even now one frequently sees that there is kind of an underlying assumption that if a person is mentally retarded they will be incapable of substantial work; or if they are capable of work it is very likely to be in a sheltered workshop at relatively low wages.

Now I looked at 27 follow-up studies of the mentally-retarded, which was all I could find, and, indeed, I found in those studies that the rate of employment among the mentally-retarded was very low and that earnings were very low.

Now the fault was not among the mentally-retarded. The fault was among the analysts because the analysts were not examining the data very carefully, because when you begin to go back and look at some of the demographic characteristics of the retarded, whose earnings were low and whose employment was low, one found that almost all follow-up studies were conducted shortly after the mentally-retarded left school and their age range tended

to be 15, 16 and 17. Yet their earnings were low, but so were those of all 15-, 16-, and 17-year-olds.

[11-111] When one begins to examine these studies carefully and begins to look at the age-earnings profile over time then one came to remarkably different conclusions. There were, fortunately, some studies that did follow up studies of the mentally-retarded into the middle age of the mentally-retarded cohorts and what I concluded — and this is based on studies, fine studies that were done in Connecticut and Iowa — were that among the mildly-retarded, and I emphasize this is the vast majority of the retarded, that males had employment rates, and I mean actual work rates of 87 percent, which was only four percentage points below the employment rates of the general population.

Even more surprising, I found that their earnings were about 86 percent of the average, which meant that from a vocational standpoint the success rate was very high.

Among women the employment rates for the mildly-retarded were 33 percent, which at that time was about 12 percentage points below the average for women in the United States.

This does not mean that they were vocationally unsuccessful because we found that many mildly-retarded women that were married simply chose to be homemakers rather than to go into the work force.

This is a very difficult field for the retarded that generally existed before and I am afraid exists in many people's minds at the present.

Q. Dr. Conley, does that apply to just mentally-re-

[11-112] tarded persons who are in the community or are mentally-retarded persons in institutions also capable of employment?

A. These follow-up studies were done almost en-

tirely — well, they were done entirely on the mentally-retarded in the community.

There is no reason to think that the mentally-retarded in institutions would have significantly worse work potential.

I have been very impressed by at least one study done in Pennsylvania of Polk State Institution that indicated — this is before the peonage act, so we no longer allow residents to work — but at that time, at least, one in two adults in the institution worked on institutional activities and what was even more interesting was that the majority of those who were in the institution working were in the moderately-severe mentally-retarded range. As a matter of fact, the number of mentally-retarded residents who were working outnumbered those who were paid by a ratio of two to one, so there is no question that they were found capable of work.

In point of fact, it is difficult — let me back up a minute.

The question that they can work is well established because we see them working. The question of whether they can find meaningful work is a more pertinent one because it is very difficult to find
[11-113] meaningful work for all the residents in a large institution on institution grounds, and I do not regard sheltered workshops in general as providing meaningful work.

Firstly, if you place a thousand, 1500, 2,000 residents in an institution in the country, without providing the transportation to an urban area, it is manifestly impossible to find meaningful work. It simply can not be done.

Q. Is your testimony that these people could find work if they were living in the community?

A. Yes, I believe that most mentally-retarded are capable of work. It has been demonstrated that they are capable of work and if placed in a community

setting with good community services, and community services have not always been good in the past, in fact, they have been quite bad — but given good community services that employment is very feasible.

* * *

[11-114] Q. Dr. Conley, how did you, as an economist, determine the total cost or expenditures for residential care or care in a particular facility, such as a public institution?

A. Well, as an economist, what I look for when I am attempting to estimate cost is something we call social cost, which is a fancy term for something that is really very, very simple. We want to know the full cost to Society of operating programs.

Take the case of institutional care. In Pennhurst in Fiscal 1976 the cost was about $32,000,000 or $69 per day. This actually understates the actual cost to Society of operating that facility.

The major component of living cost is the fair rental value of the building, which I would roughly estimate to be three or four dollars per day, so that the actual social cost — it was really costing the citizens of Pennsylvania to maintain the facility at Pennhurst in excess of $70 per day.

One of the fascinating — I shouldn't say fascinating, it is a very disturbing thing that has happened in institutional costs — is the enormous rise in institutional costs that has been taking place over the last 10 years. Between 1968 and 1970, when I

[11-115] was doing my work, institutional costs rose by 35 percent. Now let me give another example.

In 1970, when I was working, when I was developing some of these cost estimates, we were talking about annual cost in a residential facility of un-

der $5,000 and now at Pennhurst we are talking about average annual costs that were running about $22,000, and these increases in costs are astounding.

Q. Dr. Conley, you mentioned that *per-diem* cost at Pennhurst was the direct cost, not including the social costs, and would be $69 per day.

What was your basis for arriving at that figure?

A. That figure was arrived at by dividing the operating costs reported by Pennhurst by the resident population.

Q. Dr. Conley, in addition to your study of institutional care have you studied costs and benefits in other services to retarded persons?

A. Yes.

MR. LASKI: May I approach the witness, Your Honor?

THE COURT: Yes.

I have another question.

BY THE COURT:

Q. Doctor, I don't know, it goes back to the one I asked sometime ago. I believe you told me that according to your studies there were approximately 270,000 retarded in institutions as you defined the word.

[11-116] Were you able to break that down according to states and, if you were, what was it for Pennsylvania?

A. I could have broken it down for states, but I have to be honest. I don't have the information for Pennsylvania again —

Q. All right.

A. — at hand.

THE COURT: All right.

BY MR. LASKI:

Q. Dr. Conley, I show you PARC Exhibits Nos. 63 and 64.

Do you recognize these documents?

A. Yes, I do. They show the *per-diem* costs of operating community-living arrangements in Pennsylvania.

Q. Dr. Conley, what are these documents again?

A. They show the *per-diem* costs of operating community-living arrangements in the State of Pennsylvania, that is one document; and the other document indicates the cost of providing services to the mentally-retarded, some of the mentally-retarded in the community-living arrangement and sheltered workshops.

Q. What is the statewide average *per-diem* cost for community-living arrangements that are reflected in those documents?

A. The statewide cost is $17.64.

Q. And is there also an estimate there for cost of program services to accompany the cost of residential care?

A. For those persons in program services, which are about one third of the total community-living ar-

11-117] rangements, there is an estimate, which is $10 a day.

* * *

11-119] BY MR. LASKI:

Q. Dr. Conley, have you analyzed those figures on Exhibit 64 and reached any conclusions about them?

A. Well, I analyzed as well as I could in a short time.

I would say that one thing that does need to be made clear is that the figure of $17.64 understates the actual cost to the citizens of Pennsylvania of what community-living arrangements actually involve.

There are additional costs that have to be taken into account, one of which we have already men-

tioned, which is the cost of providing services to residents in sheltered workshops.

There are other costs that I did not see in the budget. I did not see, for example, any allocation or any consideration of the cost of special education that would be provided to some residents, which is, indeed, the type of cost that an institution like Pennhurst would incur and should have been included in these figures.

* * *

[11-121] BY MR. LASKI:

Q. Dr. Conley, you were saying that the cost of $17 per day for residential care and $10 per day for services somewhat understates the social costs.

Have you made any calculations from which you would conclude what the actual cost would be for a person living in a community-living arrangement in the five-county area?

A. Yes. It I was, you know, developing a formal estimate of social costs, I would begin with these operating costs and then look for other expenditures that were being made on behalf of the residents.

Certainly, the money spent on those residents in sheltered workshops would have to be included. Funds spent on special education would have to be included.

I did not see in the budget any allowance for medical care. That would certainly have to be taken into account.

Nor did I see any allowance for the cost of monitoring or managing the program that was incurred by the mental health-mental retardation units in the various counties.

[11-122] Now roughly I would estimate that special education programs would probably be about $4,000 per year per student, which is based on the fact that

education generally is running about $2,000 per year for students and special education is usually about twice that amount.

The provision of medical care I would estimate to be about $600 per year and case management about $500 per year.

When you translate these into *per diem* rates then you come up with the following type of very rough calculation, but in looking at social costs, if we were looking at that part of the retarded population who were attending public schools, special education classes in public schools, then one would add to the $17 that is on the exhibit another $14, which would be roughly the cost of case management, special education, and medical care, or about $31.

If you are looking at the social costs of maintaining residents in community-living arrangements who were being served in sheltered workshops, then to the $17 you would add $10, which we talked about, mentioned earlier as the average daily cost of providing services for these residents in sheltered workshops, plus another $3 for medical care and management, or about $30 a day.

If you were looking at the social cost of those residents who required minimal type of developmental services than one would take $17 and add
[11-123] about $3 to allow for the management and the medical-care components, or about $20.

Now if you take these three groups together and look for an overall average that would be comparable to this $17, which represents the social cost to the citizens of Pennsylvania, then I would roughly estimate it at about $27, which is suprisingly lower than the very high Pennhurst figure of $69, actually over $70, if you consider social costs.

And a good part of this expenditure represents what economists call investment activity of people,

that is, we are spending money on residents and facilities to help develop their vocational and social potentials for the future.

* * *

[11-124]BY MR. LASKI:

Q. Dr. Conley, I show you PARC Exhibit No. 33, entitled "Needs Assessment and Budget Projections on Deinstituionalization of Montgomery County Persons Residing at Pennhurst Center."

Do you recognize that document?

[11-125] A. Yes, I do.

Q. Have you studied that document?

A. Yes, I have.

Q. And what does that document reveal about the cost of commmunity programs for Pennhurst residents of Montgomery County?

A. Well, the document indicates that the average — no, the annual cost of moving the 133 residents from Pennhurst to the community would be a little bit less than $2,000,000 per year, $1,900,000, to be more precise.

Q. And does that document break out that cost in any way?

A. It breaks it out by the type of facilities that will be needed. For example, in dealing with the retarded, as we have already indicated, the retarded are a very heteroganeous group, that is, they are individuals, they are different from each other and have very different needs; so that the type of community-living arrangements that will be required will also be very different.

Table 2 in this document indicates the average cost for a range of five different community-living arrangements that would have to be provided for the different individuals. These costs range from $20 to about $38 per day.

Q. Do you have an opinion, after a study of this document, as to whether the cost estimates provided by Montgomery County are correct?

A. This cost estimate provided by Montgomery
[11-126] County and the description of the population to be served represents, I must say, one of the finest documents I have ever seen on planning for deinstitutionalization. They contain the type of information that Montgomery County would have to have in order to implement deinstitutionalization.

As a matter of fact, they do somewhat understate social costs for the same reasons that we talked about before, that is, they don't include the cost of providing special education, for those residents who require special education; they don't include any costs for management and they don't include any type of costs for ongoing medical needs of the resident population.

On the other hand, they do one thing that overstates costs, and that is that they include capital expenditures, which were about $100,000 in the budget. Now from a social standpoint any type of capital expenditure ought to be capitalized and depreciated over time, that is, it shouldn't charge off the full cost of any capital expenditure to a given year.

So that they were offsetting biases.

My best estimate would be as to the actual range of costs that would be relevant to the State of Pennsylvania, that is, the taxpayers would ultimately have to pay, would be somewhere in the area of $25 to $45.

BY THE COURT:

Q. Would you mind reading to yourself that foot-
[11-127] note at the bottom of Page 1 of that memorandum of February 28, the first page?

It says 130 clients for one year at Pennhurst equals what?

A. $2,888,730.

Q. Now do you know what that figure is?

A. That figure would represent an estimate of what it will cost the taxpayers of Pennsylvania if, instead of removing the residents of Pennhurst to a community-living arrangement, they must remain at Pennhurst — the cost of leaving them there, that is, the *per diem* costs, will amount to almost $3,000,000, which is far above what will be incurred if they are removed to the community.

BY MR. LASKI:

Q. Dr. Conley, would you once again give the range of daily costs for community-living arrangements that are reflected in that exhibit?

A. In Montgomery County?

[11-127] Q. In Montgomery County.

A. Well, the budget that was approved by Montgomery County gave a range of $20 to $38, which would depend on the type of facility, the highest-cost facility being a children's developmental facility which would require a good deal of individual work with the child.

Q. And is it your opinion that these estimates are

[11-128] correct and accurate estimates of the cost of care of a retarded individual in the community in Montgomery County?

A. If I was preparing a document to help choose among the alternatives of leaving individuals in Pennhurst or removing them to the community, these costs would be somewhat higher probably by a factor of three to four dollars, so that the actual range would be $24 to at most $45, which is, of course, still far below what the costs are of maintaining residents now, the retarded, at Pennhurst.

The total cost would not be much over $2,000,000.

Q. And what was the *per-capita* cost to maintain a person at Pennhurst?

A. It was $2,900,000.
Q. And that on a daily basis was what?
A. $69.

* * *

[12-19] Q. Dr. Conley, do you have an opinion as to whether it would be more costly to provide comprehensive residential and program services to those now in Pennhurst in the communities rather than to maintain them at Pennhurst?

[12-20] A. Yes, I do.
Q. Would you explain to us that opinion?
A. Yes. Based upon the documents that we have reviewed in this case, that is, the budget figures put forth on the costs of community-living arrangements from the counties themselves, based on my admittedly rough estimate of the additional costs that should be included, if one is truly to measure the cost figures that are relevant as for decision-making, that is, the social costs of community-living arrangements as opposed to allowing residents to remain at Pennhurst, allowing for the fact that cost estimates must be rough in any case, and based upon the past work I have done in mental retardation, which I guess stems back to very young days, and based upon the experience that I have gained in the area of mental retardation, there is no doubt in my mind that it is considerably less costly to provide for mentally-retarded persons in the community than in institutions.

Not only is the cost less because the services can be basically set up for the specific needs of specific residents, but there are enormous benefits in the sense that the wellbeing of the mentally-retarded and their families will be substantially improved, not just because of their ability to be employed, but because of the greater fulfillment of their lives.

* * *

Testimony of Marian Caranfa

* * *

[12-61] Q. Did you accompany George on the first day of his commitment to Pennhurst?

A. Yes, I did.

Q. Could you describe the situation as you found it when you arrived at Pennhurst?

A. Yes. Georgie was taken directly to the hospital. It was ghastly.

Here was this little seven-year-old boy and all these naked men milling around, screaming, swearing.

[12-62] He was terrified and, of course, I was heartbroken.

Q. He was admitted to the hospital ward of Pennhurst?

A. Yes, the hospital ward of Pennhurst.

They gave him a sandwich for lunch and Georgie had never been able to chew.

Q. Did anyone from Catholic Social Services accompany you?

A. A sister accompanied me.

BY THE COURT:

Q. How long had George been with you before this day?

A. All his life, seven years. He was seven years old at the time, your Honor.

MR. FERLEGER: He came to her when he was —

THE WITNESS: Five weeks old when he came to us.

THE COURT: Thank you.

BY MR. FERLEGER:

Q. Now the records indicate that in November 1969, shortly after he was admitted, he went to the habit-training ward.

A. Yes.
Q. Do you recall that ward?
A. Yes, I do.
Q. And could you describe the conditions and facilities available on that ward?
A. That was a large ward, upstairs, on top of the hospital, on the third floor.

There was a large day room with a stone floor.
[12-63] The bed quarters were over to one side. There was a great big — it looked like a play-pen, only it was six-foot sides.

I have learned later that it was a cage that they put patients in that misbehave. I never saw anyone in there.

They did have toys in there but they were never allowed out.
Q. The toys were —
A. The toys were in the cage and they weren't allowed to have them out. I never saw a toy being played with ever.
Q. But the toys were there?
A. They were there in the cage.

There was frequently urine and feces on the floor, under their fingernails, in their hair, and still is.
Q. Do you recall whether George was ever injured during the months that he was on that ward?
A. In the seven years that Georgie has been in Pennhurst there have been maybe four times that he had not been injured.

I go to see Georgie every week. Occasionally it has drifted to two weeks if I have been sick.
Q. You say four times. I am not sure —
A. Four or five times out of seven years that he has not been injured.
Q. I don't know what you mean by "times".

Do you mean times that you have visited?

[12-64] A. Times that I have visited.
Q. Restricting our conversation right now to the habit-training ward, do you recall any injuries he suffered specifically on that ward?
A. Yes. He was always bitten, scratched, black eye.
Q. Did you ever make any complaints to the staff?
A. I complained constantly.
Q. What was the result of your complaints on the habit-training ward?
A. They tried to keep me out of it.

* * *

BY MR. FERLEGER:
Q. The Pennhurst records indicate that George moved to Ward D-1 in May of 1970.
Do you recall that move?
A. Yes, I do.
Q. Could you describe the conditions on the ward as you saw them on your visit between May of 1970 and December of 1970, when he left — excuse me — and August 1971, when he left the D-3 area?
A. D-1, do you mean, to go to D-3?
[12-65] Q. Excuse me.
He was on D-1 just briefly and then he went to D-3?
A. Yes. He was in D-1 —
He was in Ward D-1. It was another large ward. There were maybe thirty-five or forty children in it.
They had French doors leading into their bed area and another set leading into where they ate. It was all almost like one big room.
There were no toys there.
He was always bitten, scratched, had black eyes, had his teeth knocked out.
Q. Now were you informed by any Pennhurst employees of any desire on their part to restrict your visits?

A. Oh, yes.
Q. And what employees informed you of that?
A. Paul Metzger and Janice Allen. They had a letter they wanted me to sign, saying that I would not interfere with the aides in the performance of their duty.

* * *

[12-66] BY MR. FERLEGER:
Q. Going back to not the latter time when Paul Metzger advised you of something, but earlier on in 1970 and '71, when George was on D-3, were you advised by any employees back then of any desire of their part to restrict your visits?
A. Yes.
Q. And who were the employees who advised you?
[12-67] A. Janice Allen.
Q. Did Norma Beard advise you?
A. Yes.

* * *

BY MR. FERLEGER:
Q. And why did they tell you that they desired you to limit your visits?
A. Because I complained and they said that that disturbed them.
Q. Disturbed who?
A. Disturbed everybody.
Q. The residents or the employees?
A. The employees.

* * *

Q. Were there ever any injuries that George received that came to the attention of Dr. Youngberg?
A. Oh, I tried, but I never could get in to see him.
Q. What would happen?

A. One day I went to see Georgie and he had a bite as big as a grapefruit on the inside of his knee and I waltzed him right over to the office.

Of course, I didn't get to see him.

On many occasions I called him and tried to get
[12-71] to see him.

Q. And what was the response of Dr. Youngberg to those requests?

A. I never saw him and I could never get past his secretary.

Q. Did Dr. Smilovitz or any other officials ever become personally aware of any injuries to George?

A. Yes. On that occasion of the large bite on the knee, Dr. Smilovitz came out and spoke to me and he sent for Norma Beard and we talked together.

I wanted Georgie placed in a ward where he wouldn't be hurt in this way. I wanted him removed from the biters and the stronger children; and they said there wasn't any place else they could put him and I would just have to be satisfied to leave him where he was.

Q. Do you know if any doctors at that point saw that particular injury?

A. Dr. Robles was in the office when I went to dress George and saw the bite and I became excited and she said, "I don't blame the parent, this is a vicious bite."

* * *

[12-78] Q. Did you ever see any abuses of residents by aides on D-1?

A. Yes.

Q. And will you describe that, please?

* * *

Q. Do you recall about when that was? '72, '73, '74?

A. Around '72.

Q. Will you describe that?
A. Yes. An aide — it was around mealtime. I went in the dining room to help feed Georgie.

As we went into the dining room a patient was getting a drink from the soda fountain. The aide struck the patient and swore at her.

We all went into the dining room. While I was feeding Georgie the aide was slapping several different patients about the arms and shoulders and then she took one child by the back of the neck and held open the swinging door with one hand and threw the child through and he landed on all fours in the other room.

[12-79]

At that time I went downstairs and told Norma Beard there is an aide up there mistreating those children.

Q. Do you know how far the child was thrown?
A. Five or six feet, I'd say.
Q. The child started out in the air, off the ground?
A. Yes.

* * *

[12-80] Q. The records indicate that George was on Ward D-1 from November of 1971 to May of 1972.

Do you recall any incident on that ward that stands out in your mind?

* * *

The Witness: Well, what do you mean, incidents involving Georgie or other patients?

BY MR. FERLEGER:

Q. Either.
A. There was one time when there was a baby lying on the floor and the flies were in her mouth and nose and I picked them out and asked the girl who worked at Pennhurst, Dorothy, in charge of the ward, to do something about it.

And she said, "Well, what do you think I can do?"

[12-81] And I came downstairs and complained to Norma Beard and I said they should have the baby in a crib with mosquito netting over the crib.

It was summer and there were a lot of flies drawn by all the urine and feces all over the place.

And when I came the next week the baby was in an inner crib and they had a netting, it looked like a big fishing net. It had holes in it this big, and a dive-bomber could have went through the holes and got on the baby's face.

* * *

[12-82] Q. Were residents showered in the normal fashion on the ward C-1?

A. On the T building they had a big room with a broken cement floor. I got there very early one day to take Georgie out for the day and they were being squirted down with a big hose.

There was a crippled girl about eighteen naked in the wheelchair, in the doorway, trying to dry them as they passsed out of the room.

[12-83] Of course, the children were all screaming hysterically at this procedure.

Q. Screaming with delight or happiness?

A. Delight? Screaming with fear.

* * *

THE WITNESS: I know my baby was scared to death. Let's put it that way.

BY MR. FERLEGER

Q. Do you recall Christmas 1976?

A. Yes.

Q. Did you pick up George at that point and come home?

A. Yes.

Q. Could you describe his dress at that time?
A. Yes. I had bought Georgie a coat in the beginning of the year and it was torn, he wasn't able to wear it.

They gave him a coat that was an absolute rag. The sleeves were all frayed, the zipper was torn out of the front. They closed it with a big pin.

We stopped at the first store and bought Georgie another jacket, and when I came home I called Dr. Youngberg.

[12-84] At this time I did get him and I told him that my son should be dressed in better fashion and he agreed with me.

But subsequently Georgie never did get another coat.

Q. This was the coat they gave him to go home for the weekend?
A. Yes.
Q. To the community?
A. Yes.
Q. Was George Sorotos ever physically restrained in any way?
A. Yes. When he was in D-1 I used to go up and see him and he would be —

MR. WATKINS: Objection as to the time, your Honor.

BY MR. FERLEGER:

Q. That would have been, as I look at the records, from June of 1972 to May of 1973?
A. As nearly as I can remember.

He would be tied to the bench. Often he would be walking around the floor on all fours pulling the bench with him.

Q. I don't understand.
A. Well, he would try to get up and he'd fall over. The bench was tied to his back, so he would just drag it around.

[12-85] Q. Did you ever see any physical marks or injuries from that?
A. He got many bruises from the tightness of the band until one day I said I never, never wanted to see that on him again; and then I didn't.
Q. Mrs. Caranfa, I show you Defendants' response to Interrogatory 19 of the plaintiffs regarding George Sorotos.

The question was whether physical restraints or seclusion had ever been used on the plaintiff, and I note only one incident that's noted, of October 31, 1974 — seclusion for pulling hair and punching boys and aides; but nothing about restraints.

Is it your testimony that this is not a reflection of the number of times he was under restraint?
A. That's not true. I became alarmed at the restraints after Dennis died.
Q. Dennis?
A. A patient. He was restrained and strangled to death.

* * *

[12-87] Q. Has George ever been burned at Pennhurst?
A. Yes.
Q. Can you describe what you know about that?
A. Only what I see, and they look like cigarette burns on his chest.
Q. And how recently have those burns been observed?
A. A couple of months.

* * *

Testimony of Doris Taylor

[13-11]BY MR. FERLEGER:

Q. Mrs. Taylor where do you live?

A. 51 Trellis Road, Levittown, Pennsylvania.

Q. You are the mother of two of the plaintiffs in this case, Lawrence Taylor and Kenneth Taylor?

A. I am.

Q. When was Larry Taylor born?

A. February 14, 1956.

[13-12] Q. And how did you come to know that he was retarded?

A. Quite a while after he was born. He didn't develop normally. At the end of a year he couldn't even hold a rattle, he couldn't roll over.

He just laid on his bed on his back, with his head on the side.

Actually, it wasn t a doctor that told me that he was retarded.

Q. What did the doctor tell you? What did you learn from the doctor when you brought symptoms to the doctor's attention?

A. Well, they kept treating him like a sick child. I mean they never mentioned anything about development or anything else.

He was very tiny when he was born. He only weighed three pounds three ounces.

When he was only a month old they thought he had hydrocephalus and was sent down to Children's Hospital.

Q. When did you learn that he was retarded?

A. I tried to enroll him in a pre-school program and he didn't qualify.

Q. How old was he?

A. Oh, I am really not sure. He must have been about three.

He wasn't toilet-trained; couldn't feed himself.

At that time he could sit, but in a sitting position on the floor he couldn't move. I mean he just sat and to qualify for any pre-school program he
[13-13] would have to be able to take care of himself.

So the woman that was taking the applications actually is the one that said that he was retarded and to her knowledge there wasn't anything in the community to put him into.

* * *

BY MR. FERLEGER:

Q. Did you get any assistance at all from any community programs with Larry Taylor?

A. The only thing I got was through Easter Seals. They had given me a few exercises to strengthen his legs and at one point they suggested a standing box to teach him to stand.

Q. And how long did those exercises continue?

A. They continued until Ken was born.

Q. And when was that?

A. He was born November 13, 1957.

Q. And how does he come to be retarded?

A. When he was three months old he contracted a virus. He was very, very ill.

* * *

Q. How did you come to know that he would be retarded?

A. Well, he seemed to be perfectly normal before he went into the hospital. When he came out he couldn't do anything. He couldn't hold his head up.

He was pretty much in the same condition as Larry at that point.

Q. And what help did you get in the community in caring for him?

A. Nothing.

Q. Did you ever contact any county officials?

[13-15] A. Yes, I did. There was a woman that came to my house quite frequently and they suggested I put both children on the waiting list for an institution. I can't remember the name, but it was strictly for crib cases.

Q. And did you do that?

A. I told her I couldn't do that. I said that I had worked so hard with both kids.

I did get them to the point, both of them, where they could sit and they could get around in baby-walkers; and I said I just couldn't do that.

What I wanted for them was some place to give them physical therapy, to teach them the things that they didn't know.

Q. How did you come to consider admitting them to Pennhurst?

A. I finally got to the point of desperation. Larry, he never slept at night, he never slept during the day. He would cry continually.

The only way I got any sleep was if my mother would come in once in a while and relieve me.

The two children were in the same room. If one started, if Larry started he got Ken up and I had to stay up at night because my husband had to work. He needed his sleep.

And it was a strain during the day and one thing led to another and unless you have been
[13-16] through this you never know how bad it is.

I really thought I was loosing my mind, so finally, Miss Harr, that was the lady's name, she suggested —

* * *

BY MR. FERLEGER:

Q. The woman you mentioned, were did she work?

A. She worked for the County, but I am not just sure what her position was.

Q. And what happened with regard to committing the children to Pennhurst?

A. She did all the arranging, and like I say, I was in such a mental state that in January of 1961 she took Larry and put him in a private facility, hoping, she said, that the application for Pennhurst would be through shortly, but she realized that he was the worse of the two.

And I just couldn't go on any more and, as it turned out, in February of that year, Pennhurst did
[13-17] contact me and they were accepted.

* * *

[13-24] Q. Were you ever asked for permission by anyone on the Pennhurst staff for the drugging of your children?

A. Never.

Q. Were you ever given any information about the effects and side effects of drugs they were receiving?

A. Never.

Q. Did you ever make any inquiries of the Pennhurst staff regarding the medication of your children?

A. I did for Larry because he got to the point where he was so lethargic that he could barely walk. After 1971, when the children went off the grounds to school, he would fall asleep in school.

So I really don't think he got anything out of that and I did ask, you know, what he was on.

I found out that he was on Dilantin for seizures. My child only had one seizure in his life and that's
[13-25] when he was a baby.

Q. Were you ever told that Larry was an epileptic by Pennhurst?

A. No.

Q. Were you ever given any indication at all that they considered him an epileptic?

A. No. I was not.

Q. When you took him home on weekends did you get seizure medicine, like Dilantin to take home for the weekend?
A. I didn't bring him home because I had brought them home on a couple of times and they said that they felt that they regressed at home.

So actually we went there to visit rather than bring them home.
Q. Did you ever discuss the drugging of Larry with Dr. Youngberg?
A. Yes, I did once. We were at a parents-staff meeting.
Q. Do you recall about how long ago that was?
A. No, not really.

I can't give you an exact date, but Larry, as I say, had reached the point where he couldn't get around and I had carried him over to Dr. Youngberg and I told him to look at my child, he was almost a vegetable.
Q. And did you discuss with him whether this was the result of Larry being on medication.?
A. I told him I felt it was.
[13-26] Q. And what did Dr. Youngberg reply?
A. He shook his head and said "Shouldn't be, shouldn't be."
Q. Did you ever hear back from him regarding that complaint?
A. No, I didn't; but I did finally, after all those years, get to talk to Larry's doctor.
Q. And what was the occasion for that happening?
A. It was at one of the very few meetings that I attended and I explained to her to my knowledge; you know, he had never had a seizure, I couldn't understand why he was on this medication.

This was not the doctor that prescribed the medication, by the way.
Q. Okay.

Now did you make these complaints about the medication to the entire team meeting?
A. I did.
Q. And your testimony was that there was a doctor there at the meeting?
A. Yes, there was.
Q. And who was that?
A. Dr. Robles.
Q. Enid Robles?
A. That't right.
Q. And what did she reply?
A. She listened to me. Finally somebody listened to me and she said she would —

* * *

[13-27] THE WITNESS: She said she would check into the record, which she did; and she did get back to me and she checked way back; you know, she said, when he came to the institution, and she could find only one episode of a seizure and she agreed to remove him from the Dilantin.

BY MR. FERLEGER:
Q. And do you know whether that happened?
A. That happened, but then I didn't find out until later he was put on Mellaril.
Q. And were there any problems with the administration of Mellaril to Larry Taylor?
A. There again he got very lethargic.

* * *

[13-28] BY MR. FERLEGER:
Q. Did you make any complaints regarding the effect of drugs on your son?
A. Yes, I did.
Q. To whom?
A. I spoke with Nancy Everson and I spoke to another social worker later, Paul Metzger, about it.

There was no reason given to me why he was on Mellaril.
Q. Did they agree that the Mellaril was causing the lethargy?

A. Yes.
Q. And did anything come of your complaints regarding the Mellaril?
A. No.
Q. Where is Larry Taylor now?
A. At Woodhaven Center.
Q. Does he receive medication there?
A. No, he does not.
Q. Does Kenneth receive any medication now?
A. Kenny is still on Mellaril. I am trying to get him off that.
Q. And where is Kenny now?
A. Woodhaven Center.

* * *

[13-29] Q. Do you recall seeing in my office a list of accident and injuries that the children received?
A. I did.
Q. I notice that many of those accidents are characterized as minor by Pennhurst.

Would you agree with that characterization?
A. I certainly would not.
Q. Why not?
A. I suppose there is — well, I should not say that.

The accidents that I witnessed with both of my children, many of them were quite serious, I felt. Many of them required a number of stitches in the head area, in the face area.

They were battered and bruised, bitten, scratched.
Q. Were either of your children ever hospitalized within the hospital at Pennhurst for any of these injuries?
A. Larry was.
Q. Will you describe the length and nature of the hospitalization?

[13-30] A. He was beaten about the head and face so badly he was unrecognizable. You couldn't see eyes, nose, and mouth. I mean he was totally beyond recognition.

He spent two weeks in the hospital.

Q. If a network of community services were available for the care of residents at Pennhurst, would you agree that Pennhurst should be closed?

A. (There was no response.)

Q. Can you can explain your answer, if you wish.

A. Yes. There is nothing more that I would like as a parent than to have my children close to home.

I do realize that they require a lot of structure, a lot of reinforcement. Such a facility is not available at this time.

Q. Did you ever have any contacts with your base service unit regarding the stay of your children at Pennhurst?

A. To tell you the truth, I wasn't aware of a base service unit until right before my children were transferred from Pennhurst. That was my first contact.

Q. The base service unit had never contacted you about your children?

A. No, they had not. Even then they didn't. I called them.

Q. And that's how your children got out of Pennhurst?

A. Not through the base — well, I suppose — I can't give you an honest answer on that.

[13-31] I suppose Pennhurst worked along with them but without my knowledge.

* * *

[13-39] Q. Have you been contacted by the base service unit since that initial contact that you had when they were transferred?

A. Yes, I have been.
Q. Are you having regular contacts with them now?
A. No, indeed, I do not.
Q. How many times have you had contact with them?
A. Initially, quite frequently; but then I got a new social worker and I haven't really talked to them at all to any degree.
Q. Are you discussing or have you discussed community placement?
A. I tried to.
Q. Why do you say tried to?
A. Because I called him and wanted to know if there was anything in the community.

He acted as if he didn't even care to discuss it with me. He has not turned up at my children's program-planning.

[13-40] Q. This is at Woodhaven?
A. Right.
Q. Do you recall his name?
A. I only know his first name.
Q. What's that?
A. Richard.
Q. And he is with the Bucks County —
A. He is in Penndel.
Q. I am sorry?
A. In Penndel.
Q. Is he a County employee, as far as you know?
A. As far as I know.

* * *

Testimony of Elizabeth Bowman

[13-67] BY MR. FERLEGER:

Q. Mrs. Bowman, how old are you?

A. Fifty-six years of age.

Q. And where do you live?

A. 146 Mildred Avenue, Roslyn, Pennsylvania.

Q. In what county is that?

A. That is in Montgomery County.

Q. And you are the mother of the plaintiff, Nancy Beth Bowman?

A. Yes, I am.

Q. When was she born?

A. December 12, 1950.

Q. And were her first couple of years of life normal?

A. Yes, they were.

Q. Then what happened?

A. At the age of nineteen months Nany Beth developed or contracted encephalitis, which left her severely brain-damaged.

Q. And is that when you learned that she was retarded?

A. Yes, I did.

Q. What sort of care did she receive for the first
[13-68] four or five years of her life?

A. Of course, we went from doctor to doctor for tests and enrolled her in a private day school in Chestnut Hill that had programming, speech therapy. She received speech therapy and they taught her to read and to print and she was there for about two and a half years and the school had to close its doors due to a financial problem.

Q. And then where did she go?

A. Nancy Beth didn't go any place after that. We contacted our school district to see if they ad a program for Nancy Beth and at that time there wasn't anything available.

Q. How old was she then?
A. She was six then.

When she was seven years of age the Abington School District set up a day-care program for mentally-retarded youngsters and Nancy Beth was enrolled in that program for about a year and a half.

During her first six months Nancy went to a full day program. However, due to her hyperactivity, — Nancy Beth is extremely hyperactive — they —
Q. What kind of hyperactivity did she exhibit then?
A. She was in constant motion. She could not sit still for periods of time.
Q. Did she hit anybody, bite anyone, hurt anyone?
A. No she was not abusive.
[13-69] Q. What precipitated your consideration of committing her to Pennhurst?
A. We did not have any other programs in the community for her and she became difficult to handle on a twenty-four-hour basis.
Q. Did you get any help from the Montgomery County Health and Welfare Department?
A. We contacted Montgomery County Health and Welfare Institutional District to see if there were any places available for Nancy Beth and they at that time informed us that there were state institutions for her.

However, our doctor, in the early years of Nany Beth's training, advised against placing Nany Beth in an institution. That's why we were looking for outside help so that she would not have to go to an institution.
Q. Did you visit Pennhurst or any other State institution prior to admitting Nancy Bowman there?
A. Yes, we did. We went to many private institutions.

However, the tuition fees were beyond our means and we were out to Elwyn and Pennhurst.

We did tour Pennhurst prior to Nancy Beth's admission.

Q. What did you see on that tour of Pennhurst?

A. Of course, we were shown the high-functioning-level wards at Pennhurst, where children were participating in the school program. We were shown

[13-70] the sewing classes that the young women were sewing, and their cooking classes, which they said residents were able, with training, to get into these programs.

Q. What was Nancy Beth's physical condition at the time she was admitted to Pennhurst?

A. She was in perfect physical condition.

Q. Did she have any scars that you know of?

A. Yes. She did have one scar on her lower left arm. We had a storm door installed in our home and we were not aware that it was not safety glass in this storm door and due to an accident Nancy did not know the door was locked and she pushed on the door and went through the bottom of the storm door.

Q. Did she have any other scars?

A. No. she did not.

* * *

BY MR. FERLEGER:

Q. At the time that she was admitted to Pennhurst

[13-71] did she have a habit of biting other residents?

A. No, she did not.

Q. Do you recall, if you know, about how long after her admission she developed that habit?

A. I believe it was in her second year at Pennhurst when she developed maladaptive behavior or biting.

Q. In those early years of her commitment at Pennhurst did you visit Nancy Bowman on the wards?

A. No. Parents were not allowed to visit the patient on the ward.

However, I did request permission. I was interested to find out what type of living arrangements were made for her, so I did have permission to have a visit to the ward.

Q. And that would have been in the early 1960s?

A. That was in the early 1960s.

Q. Could you briefly describe what you saw?

MR. GOLDBERG: Will you note my objection on the time period, your Honor.

THE COURT: The objection is noted.

You may proceed.

THE WITNESS: It was a large room with sixty-five residents and the majority of the times there were two child-care aides in attendance.

BY MR. FERLEGER:

Q. And what else did you see on the wards?

[13-72] A. Well, then — the first ward she was on, they were school-age children and we were hopeful that Nancy Beth would enter the school program that Pennhurst had for children.

When we first visited the ward the majority of the girls were in session in school.

Q. Did you ever receive any requests from Pennhurst staff or officials during the 1960s for medication of Nancy Bowman?

* * *

THE WITNESS: We never received, we never were requested to give consent for mediction to Nancy Beth.

BY MR. FERLEGER:

Q. Was that during the 1960s or during the entire time?

A. That was in the 1960s, in her early years at Pennhurst.

Q. Do you know whether she was injured at all at Pennhurst during the 1960s?

* * *

THE WITNESS: Yes. We would visit Nancy Beth quite frequently and when she would be brought down to us in the visiting room we would see that she was bruised constantly, marked, black eyes, slight things, sutures, and very lethargic.

BY MR. FERLEGER:

Q. During the early years at Pennhurst did she re-
[13-73] ceive any injuries to her teeth?

A. I'd say the first year Nancy was at Pennhurst, on a visiting day we were informed by a nurse, Miss Landis, that Nancy had pulled one of her teeth herself, pulled her teeth out herself.

In 1963 we had visited Nancy Beth and she was without one tooth and one tooth had been fractured, which they had informed me that —

* * *

BY MR. FERLEGER:

Q. Could you tell us who informed you, if you know?

A. The nurse in charge of Nancy Beth.

Q. And who was that?

A. Mrs. Landis, I believe.

Q. L-a-n-d-i-s?

A. L-a-n-d-i-s.

Q. Did any doctor speak to you also about the dental problem at that time?

A. No. We did go to the dental — the doctor in charge of the dental clinic at that time and we wanted Nancy's teeth to be replaced.

Q. What did Nurse Landis and the doctor tell you?

A. Dr. San Luis and Miss Landis, the nurse, asked us not to have Nancy Beth's teeth replaced because they felt it would be detrimental to her in the event that she was knocked down and pushed, that there
[13-74] was a possibility that she would swallow these teeth.

Q. If they were replaced?

A. If they were replaced.
Q. Were her teeth replaced or capped at all during those years?
A. Yes, they were.
Q. By whom?
A. By our family dentist.

* * *

Q. Do you know whether Pennhurst had any policy regarding dental work at that time?
A. At that time we were informed by the doctor in charge of the Dentistry Department that they did not do dental restructuring.
Q. Did there come a time when you requested a transfer of Nancy Bowman out of Pennhurst?
A. Two months — I believe it was June 1961. We were very unhappy with all our visits to Nancy Beth, that being she was constantly bruised and marked up. Mr. Bowman and I felt that Pennhurst was not a place for Nancy Beth.
Q. What did you do?
A. And we went to the Social Service Department
[13-75] and requested that Nancy Beth be dismissed from Pennhurst.
Q. And do you recall whom you spoke to and what her response was?
A. I believe I received a letter from Pennhurst asking Mr. Bowman and I to come out to Pennhurst to discuss this problem.

At this meeting —

Q. Do you recall who was there?
A. Dr. San Luis, I believe, and I believe at that time it was Mrs. Flora Gross, the Director of Social Services.
Q. Was the superintendent there?
A. The superintendent was not at this meeting. However, I had spoken to Dr. Potkanski after this meeting.

Q. Yes?
A. And they informed us that once we removed a resident from a State institution we would never be able to get her into another institution, so we reconsidered doing this.
Q. Do you recall any incident you became aware of about Easter 1970?

MR. GOLDBERG: I object.

THE COURT: The objection is noted.

You may answer.

THE WITNESS: Good Friday of 1970 we went to pick Nancy Beth up to take her home for the Easter vacation.

Nancy Beth's teeth were not in her mouth and they told — Nancy Beth told us that someone
[13-76] smacked her in the mouth and knocked her teeth out.

BY MR. FERLEGER:
Q. You say her teeth were not in her mouth.

Will you explain exactly what you mean?
A. We had Nancy Beth's teeth restored. We had a permanent bridge made in her mouth with caps.
Q. How many of her teeth were involved, do you know?
A. I believe there were four at that time.
Q. It was those teeth that were gone?
A. The complete permanent bridge, yes.
Q. Do you recall making any complaints to anyone at Pennhurst regarding the loss of those teeth?
A. Yes. We did talk to — they did call Dr. Soroka to the phone to find out what happened to Nancy Beth's teeth.
Q. And that would have been —
A. That was the same day that we picked Nancy Beth up.

He was not on duty that day but they did get him from his home to come out to speak with us.

Then we also went to Administration and talked with Dr. Hirst and told him of the incident.

Q. Did Pennhurst replace the bridgework?

A. Mr. Bowman insisted that Pennhurst take care of this problem at this time because this would have been about the fifth or sixth time that we had these teeth replaced.

Q. Do you recall whether Nancy Bowman was
[13-77] placed in seclusion at any time during the 1960s?

MR. GOLDBERG: Note my objection, your Honor.

THE COURT: The objection is noted.

You may answer.

THE WITNESS: Yes, Nancy Beth was in seclusion in the sixties.

BY MR. FERLEGER:

Q. Do you recall the longest period of time that she was kept in seclusion?

A. For days, I would say.

Q. For days at a time?

A. Days at a time, yes.

Q. Do you know why?

MR. GOLDBERG: Objection.

BY THE COURT:

Q. Did anyone at Pennhurst ever explain to you why or tell you why?

A. Yes, because she had developed many maladaptive behaviors.

BY MR. FERLEGER:

Q. Like what?

A. Biting, pushing, —

Q. And did Pennhurst staff ask you to take any action regarding those behaviors?

A. Not in the sixties, no.

Q. Now in about 1970 did Nancy move to Ward Q-2?

[13-78] A. Yes. The social worker at that time asked Mr. Bowman and myself if we could consider placing Nancy Beth in a modified — a behavior-modification program.

Q. And who is it that asked you to place her in the program?

A. Alexander Mansfield, social worker.

Q. And did he explain the nature of that program?

A. Yes.

Q. And who explained it?

A. The unit director at the time was Bruce Yoppi.

Q. Y-o-p-p-i?

A. Y-o-p-p-i, and the social worker was Joseph Scotti, S-c-o-t-t-i.

Q. And what did they tell you about the program?

A. They explained behavior modification to us that for bad behavior Nancy Beth would receive negative reinforcements and with good behavior she would receive positive reinforcers.

Q. And what were the negative reinforcers to be?

A. The negative reinforcers were to be placed in muffs and restraint and seclusion.

Q. And what did they tell you were the expected results from that program?

A. They were very optimistic and felt that Nancy Beth could be helped.

Q. And did they tell you any possible negative effects of the program, or risks?

A. No, they did not.

[13-79] Q. That was in 1970?

A. That was in 1970.

Q. Have you any knowledge about whether the behaviors that program was aimed at increased or decreased since that program was initiated?

A. I am sorry, I didn't understand.

Q. Do you know whether the abusive behavior at which that program was directed has increased, de-

creased, or remained the same since the program started?
A. Well, Nancy's behavior is the same.
Q. Now does she bite or is she abusive at home?
A. No, she is not abusive with the family.
Q. How often do you have her at home?
A. We visit Nancy Beth at least every two weeks and we have her home for vacation once every six weeks, if possible.
Q. How long?
A. For a period of four days to a week; and we also take her on vacations.
Q. And on those vacations and at home does she bite anyone?
A. No, she does not.
Q. Does she scratch or abuse herself?
A. Nancy is self-abusive, yes. When she becomes frustrated, yes, she will hit her head and hit her arms.
Q. When she becomes frustrated?
A. When she becomes frustrated.
[13-80] Q. When would that be?
A. If she is not kept busy, if she is — we can never give Nancy Beth a negative answer. If we give her a negative answer it frustrates her.
Q. Although she abuses herself, does she abuse anyone else on those visits?
A. No, she does not.
Q. From 1970 to let's say 1974, when the lawsuit was filed, on Ward Q-2, will you describe how she was dressed?
A. Nancy Beth was usually dressed in State clothing, even though there is availability of clothing which is supplied by her family.
Q. When you say her family do you mean yourself?
A. Right.
She has never — she never has shoes or socks on.

Q. Did you and your husband bring clothes to Pennhurst for her use?
A. Yes, we do.
Q. Does she wear those clothes at Pennhurst?
A. They are visiting clothes. They are used as visiting clothes.
Q. What is that?
A. When you go pick up your child, that when you take her out she will have proper clothes to wear.
Q. But not locked up in the ward?
[13-81] A. But not locked up in the ward.

Things have improved, though. I do see the residents in normal-looking clothing.
Q. Would that be since 1974?
A. Since 1974.
Q. Do you recall any incidents of abuse by staff at Pennhurst of your daughter?
A. Yes, I do.
Q. I'd like to show the Defendants' answers to Plaintiffs' interrogatories regarding Nancy Bowman.

Question Number 23 was has plaintiff ever been struck by a staff member? If yes, what action was taken against such staff member? Give details and date.

Would you read this short paragraph called Incident Number 1.

* * *

THE WITNESS: A report was made to the Unit 8 director that an employee had witnessed resident Nancy Bowman being slapped on the face by another staff member. The witness was questioned and confirmed that the slapping incident had occurred.

The staff member who allegedly had struck Nancy was questioned and admitted that he had struck her. Employee resigned effective 10-6-71 in lieu of suspension pending removal.

BY MR. FERLEGER:

Q. Is that the end of that incident?

A. Yes.

Q. Were you informed by Pennhurst of that slapping of your child by an employee?

A. No, I was not.

Q. When did you first learn of that incident?

A. When I read the report in your office.

Q. How long ago?

A. A month ago, in April.

Q. What is the second incident?

A. A staff member was observed by another employee slapping Nancy Bowman on the back and upper arms after she had bitten another resident. The incident was reported to the Unit director on the same day, 3-8-73.

The unit director interviewed the staff member involved, who admitted slapping Miss Bowman.

[13-83] Staff member was suspended immediately, 3-8-73, and upon completion of an investigation of the incident the employee was removed on March 21, 1973.

Q. When did Pennhurst inform you of that abuse of your child?

A. I was never informed of that abuse.

Q. When did you first learn it?

A. When I saw the report in your office in April.

Q. Is there a third incident there?

A. Yes.

Q. Would you read that?

A. Nancy Bowman was found with numerous large bruises on both buttocks on 12-26-73. The marks were of a suspicious nature and origin, so all staff members involved with Miss Bowman were questioned and the State Police were requested by Pennhurst administration to investigate the injuries.

After extensive inquiries and multiple interviews a staff member confessed to State Police investigators to having struck Miss Bowman with a shackle belt on the evening of 12-24-73 in an attempt to stop Miss Bowman from beating another resident.

State Police informed Pennhurst State School authorities on January 28, 1974 of the development. The employee was interviewed by the unit director and assistant director of resident life.

She repeated her confession and was sus-
[13-84] pended immediately on January 28, 1974. Upon completion of investigation employee was removed for patient abuse on February 4, 1974.

The removal action was, however, refused by the local branch of AFSCME. Removal was upheld through the third step of the appeal procedure.

* * *

[13-86] Q. Did you ever make any complaints regarding medication of your daughter to any Pennhurst employees?

A. Yes.

Q. Will you describe those complaints and what caused you to make them?

A. Well, all through Nancy's stay at Pennhurst we did complain about the medication that Nancy Beth was on because we had found in her years home with us that medication agitated Nancy Beth to the point where she was more active.

Q. Did you tell any Pennhurst employees that she was better off without the medication?

A. Yes, I did.

Q. And whom did you tell that to?

A. All the doctors that were on Nancy Beth's unit.

Q. Do you remember the names of any of the doctors or non-doctors that you told that to?

A. We complained to Dr. Leov, the nursing staff, Miss Landis, many other nurses that I cannot recall their names because this is going back years now, Dr. Fanaway.
Q. Any unit director or non-doctors?
A. Yes. I believe we discussed it with Mr. Pirmann.
Q. Greg Pirmann?
A. Greg Pirmann, now Unit Director of Unit 8.
Q. He is sitting here in court?
[13-87] A. Yes, he is; and also with Nancy Beth's social worker, who is John Schaeffer.
Q. Did Dr. San Luis or Greg Pirmann indicate whether they would take action on your complaint?
A. Yes, they did.
Q. What did they tell you?
A. Nancy Beth was removed from many of the medications that she was on.
Q. Did you ever receive any complaints or remarks from Pennhurst officials regarding the use of the drug Prolixin on Nancy Bowman?
A. Yes. Mr. Bowman and I were asked permission to place Nancy Beth on Prolixin, which was to relieve some of her hyperactivity.
Q. Do you recall about how long ago that was?
A. I would say that was approximately four years ago.
Q. And do you recall who asked you for permission?
A. Dr. Konia.
Q. Harold Konia?
A. Who was a consulting psychiatrist, and Mr. Pirmann, Dr. San Luis, I believe it was at that time.
Q. What did they tell you about the side effects or risks of that drug?
A. We were informed that there were not side effects to Prolixin.
Q. And each of those people — Greg Pirmann, Dr.
[13-88] San Luis, Dr. Konia, informed you that there were no side effects?

A. I am sure that Mr. Pirmann would not know because he is not in the medical profession.

However, Dr. Konia and Dr. San Luis felt that there would not be any side effects or adverse reactions.

MR. WATKINS: Your Honor, did the witness say they felt that or they said that?

THE WITNESS: They said that there would not be any adverse reaction to Prolixin.

* * *

BY MR. FERLEGER:

Q. Since the doctors informed you that there would be no side effects or risks from the medication, at that point did you agree to the medication?

A. Yes, we did. We gave our consent to the medication to be used.

[13-89] Q. Since then have any physical problems developed in Nancy?

* * *

THE WITNESS: I would say it was four years ago we were asked permission to give Prolixin and approximately two — two and a half years ago Nancy Beth developed tremors and shakes in the right side of her body.

BY MR. FERLEGER:

Q. Will you describe exactly what you mean by tremors and shakes?

A. Arm-shaking and right-leg-shaking, right arm and right leg shaking.

* * *

[13-90]BY MR. FERLEGER:

Q. Did Nancy Bowman's right to have visitors ever become restricted at Pennhurst at all?

A. Back in the sixties, I really don't know exactly what year, it was about '66, I believe, that as a punishment for Nancy Beth because of her behavior problems they requested that we — they refused to allow us to visit Nancy Beth.

Q. Do you know whether Nancy Bowman was involved in any speech-therapy programs at Pennhurst?

A. She is not involved in any speech-therapy program.

Q. Were you aware of any recommendation of April 29, 1975 that she be enrolled in a trial speech-therapy program?

A. The last I spoke with the speech therapist, he was not working with Nancy Beth. That was just the latter part of '76.

Q. Are you aware of any programs at Pennhurst which were successful in reducing or eliminating Nancy's abusive behavior toward others?

[13-91] A. Nancy is in programs in Unit 8. She is on a behavior-deceleration program. She is in a self-skill-help program. She is involved in recreation activities.

Q. Have they been successful in reducing her abusiveness?

A. Not in reducing her abusiveness.

Q. Were you ever told by Pennhurst that their February 17, 1977 annual program review recommended that she be placed in a smaller institution and community alternatives because of the reduction in stimuli and conflicting sessions?

A. Yes, I was.

Q. Do you know what action Pennhurst has taken to get her into that sort of alternative program?

A. I don't believe there is any alternative program.

* * *

[13-92] Q. Do you know whether Nancy received in 1975 any occupational therapy?

A. 1975? I believe maybe she did.

Q. The occupational-therapy evaluation report dated April 1st and May 16th indicates that these individual treatments were canceled due to lack of staff.

* * *

Testimony of Alexander Hersh

[13-115] ALEXANDER HERSH, having been duly sworn, was examined and testified as follows:

MR. GILHOOL: Your Honor, I have handed up to the *curricula vitae* of Drs. Hersh and Walker and Thurman, which are PARC Exhibits 12, 13, and 14, respectively.

Dr. Hersh will testify about the conduct and design of the study at Pennhurst; Dr. Walker will testify about the conclusions and recommendations from their work, and Kenneth Thurman will testify to the findings.

THE COURT: All right.

MR. WATKINS: Your Honor, if I may, you will note outstanding objection to the testimony and the conclusions formed as a result of our retaining them for the defense.

We have no objection to them testifying as to what they saw factually.

We do object to their testifying to conclusions and it is my understanding — and I don't want to make a repeated objection to those types of questions.

[13-116] THE COURT: As I understand it, this is the question I already ruled upon.

MR. WATKINS: That's correct, your Honor.

THE COURT: All right.

DIRECT EXAMINATION

BY MR. GILHOOL:

Q. Dr. Hersh, have you had occasion recently to conduct an index study of all of the facets of the operation of Pennhurst State School and Hospital?

A. Yes.

Q. Will you describe, please, the design of the study and your conduct of it?

A. Okay.

The study was requested by Wilbur Hobbs.

Q. Deputy Secretary of Public Welfare for the Southeast Division?

A. Yes, Southeast Division for the Department of Public Welfare, in December of 1976.

Mr. Hobbs and Dr. Rice, one of his associates, met with myself, Dr. Walker, and Dr. Thurman around the 22nd of December. We also had conversations at that time with Mr. Watkins — I think he was calling from Harrisburg — so that it was a multi-person conference in which they laid out for us the kind of study they asked us to do.

Essentially, what they wanted us to do was a
[13-117] comprehensive, objective evaluation of Pennhurst. They specifically asked us not to do what they called a whitewash. They wanted detailed information; they hoped for a balanced comprehensive product.

At that time there was considerable discussion about the nature of the project. We all considered ourselves to be professional people and, therefore, we wanted to make it very clear that we would not conduct a study which had any conditions about the data which we would obtain. In other words, we saw this as a professional study in which we would design the study, obtain the data, and present them with the results of the study.

I emphasize that because there was considerable discussion about whether or not we would be getting information "for the defense" and we felt that if that was all we were doing — was fact-finding for the defense — that would not be in the nature of a professional report.

So that point having been clarified, we proceeded with the study.

Q. If I may, Dr. Hersh, for a moment, Deputy Secretary Hobbs was clear that there were no such conditions upon your study?

A. Yes.
Q. And were the lawyers whom you mentioned and the Attorney similarly clear in their instructions to you?
A. That was clearly the understanding at the time.

Now as to what lawyers, there was only one lawyer, Mr. Watkins, in the conference by tele-
[13-118] phone from Harrisburg.

There was another discussion in February about the nature of the results and further delineation of the study, which I can tell you about either now or a little later.

In other words, we defined even more precisely later on the kind of results they wanted.
Q. But in either case there were no constraints put upon your professional investigation or your professional judgment in the conduct and reporting of the study?
A. I can tell you very clearly that we would not have agreed to that study if that was not the condition, that we regarded this as a professional study and I think all of us professionally are bound by these kinds of ethics.

The understanding very clearly was that this was to be a study in which we would not share the nature of the study with other people while the study was going on, but once the study was over that we could always keep copies and, of course, once the study is concluded a professional person has the right to publish his result.

I think that's the professional assumption in a situation like that, the ethical assumption.
Q. Have you retained a copy of the report?
A. No.
Q. Will you describe to the Court the study and
[13-119] your design for the conduct of it?
A. It seems to me that this trial had been going on for a long time.

THE COURT: Me too.

THE WITNESS: If it is all right with you I will hit highlights because, as you know, academic people can go into unbelievable detail, so I will cut it short.

Let me say the study took three months, three months of hard work, of very harmonious — which is not always the case. We got together and we designed the study specifically by taking the charge, as we called it, from Watkins and others and putting them together into a researchable design. There were four essential questions which we attempted to answer.

First, what is the role of an institution in the service-delivery system;

Number 2, is an institution an appropriate educational treatment facility;

3 is Pennhurst an adequate setting; and

4 if not, can Pennhurst be made an adequate facility?

We took those four questions and we drew from those four questions what we call a conceptual framework. The conceptual framework involved looking at and developing several levels of data.

The first level is system-level data. We looked at
[13-120] the Southeastern Pennsylvania system and the UR system in general as it interrelated with other systems.

We looked at the Pennhurst system.

Then what we did is we developed what we called a profile of Pennhurst. The profile of Pennhurst was very complex, so that what we did from the outset was to break down the profile into several additional levels of data.

First of all, the units. We looked at all of the nine units, specifically, their purposes, their organizational structure, and their functioning.

Then we looked at all of the programs and all of the services at Pennhurst. Each one of us was responsible for a portion of the job, so that the job interpenetrated and any conclusions we came to had to be a conclusion that was agreed upon by all three of us in order to maintain an objective kind of study.

BY MR. GILHOOL:

Q. If I may, how did you assign the research and investigative tasks among the three of you?

A. How did we assign them?

Q. Yes.

A. Why don't you let me finish the conceptual framework and then I will tell you how we divided the labor.

Q. Okay.

A. Do you mind?

[13-121] Q. Okay.

A. We looked at the units, their specific purposes, their organizational structure and functioning.

Then we looked at all the programs, all the services.

We then looked at how these programs and services came into the unit or how the people in the units obtain the services.

We then did what we felt was to be the most critical part of the study, which was that we took about a five percent stratified random sample of the population. We designed a treatment sample. In other words, we followed those sixty-five-plus people very closely to see the nature of their treatment at Pennhurst.

Now the breakdown of how we did this:

We visited every unit on the grounds. We visited during the day, we visited at night, we visited in the morning, we visited at odd hours. We visited with escorts, such as Joe Foster and others, and we visited unaccompanied.

We also read thousands and thousands of pages of documents.

Here is the breakdown:

I was responsible for reviewing medical assistance deficiencies and proposed corrections, which meant that I reviewed all the data and spoke with the people who were involved in that aspect of the institution.

[13-122] I also reviewed life safety codes, efficiencies and proposed compliances, very definitely, and those were turned over to the State attorney, Jeff Cooper particularly, on February 9th because the date was highly technical and somewhat beyond our competence.

Third, I reviewed the Executive Committee, the Board of Trustees, and the Parent Association minutes of, oh, maybe the last two or three years and attempted to get an understanding of the total administrative process and particularly the administrative style as much as I could.

I also reviewed the budget of the last few years and gave particular attention to the proposed budget for the coming year.

I also reviewed the institutional correction material, and particularly the effects of the Vecchione decision on the quality of life at Pennhurst.

I also reviewed the personnel matters, including separations, how many people were separated from Pennhurst, why they were separated, the nature of the separation process.

I reviewed several of these very carefully, very precisely including all of the data.

I reviewed the staff profile, the manpower requests, the union status, the recruitment policy, separation policy I mentioned, and civil rights compliance.

[13-123] I also talked to a number of members of the security and police force at Pennhurst.

Demographic data was reviewed by Valaida Walker.

Modality data was reviewed by Valaida Walker.

Programs and activities, we all interpenetrated on that but various of us were responsible for different parts of it. I was responsible for the exit-house program, the town-house program; and in some detail the teams, the nature of the interdisciplinary teams.

I also visited many of the programs, particularly the vocational-training programs.

We took the nine units; each one took three units. In some instances some people visited other people's units for a variety of reasons, usually for replication, validation, and observation purposes.

I reviewed in detail Units, 2, 4, and 7.

I also was responsible for an analysis of the standards of Pennhurst as applied to the standards of the Joint Commission on Hospitalization.

Then I think the best thing to do would be to let other people tell you the various parts of the study that they did, but essentially that's the way it got broken up.

The study was conducted in the months of December and January. I believe we began on December 22nd and we finished some time in February.

[13-124] We submitted two reports. We submitted an interim report on February 9th at a meeting with Mr. Hobbs, Dr. Rice, and Mr. Cooper; and in that meeting what we did is we took one of the many, many documents that lawyers produce, one of these — I am not sure what this is called, but it simply to me was a list of all the civil actions.

The three of us met, went through that line by line, and gave a written response to 168 items.

We noticed that there was a typographic error on the 167th that was repeated twice. That docu-

ment is entitled complaint on the front. It is in the United States District Court. It has a list of people, and it is also called SECOND AMENDED COMPLAINT, class, Civil Action Number 74-1345.

We turned that over to the folks I just mentioned on February 9th. We also discussed it with them and we also gave them additional detail and encouraged questions because we were, after all, their employees.

Q. What was the nature of your comment on those documents? What questions were you asked to answer with respect to that document?

A. We agreed beforehand by phone that what we would do is we would submit a written comment on each item —.

Q. And what was the comment to address? What was the question you were to comment upon?

A. Well, if I am not permitted to give findings, I
[13-125] would be revealing findings.

Is that what I understood?

Q. Were you asked to say whether, on the basis of your study, the propositions of fact set out in a particular paragraph were true or untrue?

A. Yes, essentially that's what we did.

Q. All right. Fine.

A. In some instances we gave a little more detail or we gave a staff ratio or we gave the number of treatment hours or we subjectively-objectively gave our opinion about something.

Q. So that your comment on each of those paragraphs was a factual comment or an opinion, a professional opinion based upon your study?

A. Essentially, factually. If it was an opinion we said so and in some instances we disqualified ourselves.

There are about fourteen items which deal with constitutional law and I think it was slightly beyond our competence.

Q. Now you said that was one of the products of your study?
A. That's a rather brief report. That's only about a six-page report.

The second product of our report was about a 350-page report that we submitted and we also submitted — I think this is what Mr. Watkins mentioned the other day — about a thousand pages.

[13-126] We submitted a carton full of appendices and that must be at least a thousand pages, but the report itself, as I recall, is maybe about three hundred or so pages.
Q. In either of those reports did you offer any advice on the conduct of litigation about Pennhurst?
A. Litigation? You had better spell that out.
Q. You testified thus far in describing your report that you set out to do factual findings and your opinions as professionals.

Did you offer any advice about the conduct of litigation?

Were you asked to offer any advice about the conduct of litigation of a case, of a lawsuit?
A. You repeated the same phrase — conduct of litigation. I don't know what that means.

Conduct of litigation means how do you deport yourself. I don't, quite frankly, know what you mean. I just don't understand the term.
Q. Did you tell either Deputy Secretary Hobbs or Commissioner Rice or the lawyers whom you have indicated participated in some of the conferences how to defend this lawsuit?
A. No.
Q. That was not the subject of any conversation between you and the Deputy Secretary, the Commissioner, or their lawyers?
A. It would be rather foolish to even attempt that.

No, we didn't.

[13-127] Q. Specifically, it was not the subject of any comment in either of your reports?

A. Not with me.

(Photocopy of three-page "SERVICE PURCHASE CONTRACT" between Department of Public Welfare and Dr. Alexander Hersh was marked PARC Exhibit 71 for identification.)

BY MR. GILHOOL:

Q. I show you a document that has been marked PARC Exhibit 71.

Do you recognize that document?

MR. GOLDBERG: Could we see that, please?

MR. GILHOOL: Yes.

MR. STUTMAN: I will give you a copy of it.

THE WITNESS: Yes.

BY MR. GILHOOL:

Q. What is that?

A. This is the written service purchase contract for the consultation fees, the *per diem* fee, and the travel while conducting the study.

Q. This is the contract, in other words, under which you conducted your study?

A. Yes.

Q. Dr. Hersh, you testified that there were four focal questions in your investigation.

Will you kindly repeat those questions and tell us what answers you came to?

[13-128] MR. WATKINS: I assume my objection is noted, your Honor.

THE COURT: Yes.

You may proceed.

THE WITNESS: Do you want me to answer that question?

THE COURT: Yes.

THE WITNESS: You want me to comment on the role of the institution?

BY MR. GILHOOL:

Q. Yes, sir.

A. In the service delivery system; right?

Q. Yes, sir.

Will you tell us for each of the questions what answer you came to, what answers you came to?

A. (There was no response.)

Q. The first question was —

A. The first question was what is the role of the institution in the service delivery system.

The reason I am pondering for a moment is because that is a very heavy question and it is a question which could have been debated, as you know, vigorously.

We pretty much came to the conclusion that the institution has pretty much lost its role, that it is essentially an obsolete way of treating people.

[13-129] It is based on a series of assumptions which are dated. It is based on a number of assumptions like retarded people like to be with one another; retarded people should be separate from the mainstream of Society; in an institution you can pull together under one roof all the necessary services.

There are a whole series of assumptions like that that go back to the 1900s, all of which can no longer be substantiated.

So that the conclusion we came to is that there is no role for an institutional service delivery system in Pennsylvania.

Q. The second question?

A. The second question is is an institution an appropriate educational-treatment setting?

The answer to that is clearly no, the reason being that an institution is a segregationist form of subsociety which dehumanizes people. It reduces the possibility that they can ever function in a normalized Society; and it in no way supports the idea that education and treatment are even possible.

It is essentially a form of segregation which means the needs of Society to rid itself of people who are different, who are special, who are deviant, who need special help; and it is an unsuccessful way of dealing with people.

Q. The third question?

A. The third question: is Pennhurst Center an adequate facility.

[13-130] I said in the beginning that we wanted to conduct an objective study and we wanted to do a comprehensive study. We had a lot of spirited discussion among the three of us. We had some real debates and once in a while we had to tell each other to be quiet, and this is a tough question because there are many, many lives at stake, and thus we did not take lightly the question.

We found in many ways that the staff of Pennhurst were really fine people, they were hard-working people, they were doing their best.

However, we came to the conclusion that because of the essential obsolescence of the total system and because of the complexity of the interpenetration of the various systems — Southeastern Pennsylvania, child-welfare system, mental-retardation system, et cetera, et cetera, that having evaluated all of the factors that we could put our hands on we came to the conclusion that Pennhurst is not an adequate facility.

Q. And the fourth question?

A. The fourth question is also a very serious question because again it involves many, many lives and literally millions and millions of dollars.

Q. What was the fourth question, Doctor?

A. The fourth question was, if not, can it — "it" being Pennhurst —

[13-131] If not, can Pennhurst be made an adequate facility.

We came to the conclusion that it could not, that there is no way that Pennhurst could be made into an adequate facility. It is simply too far beyond repair and there are just literally hundreds of reasons why this is the case, not the least of which is the fact that Pennhurst as the whole structure, the whole way of operating out there is simply too far gone. It is simply based in an earlier model, which is just totally obsolete, so that the answer to that is no.

Q. Dr. Hersh, have you, in the recent past, had occasion to conduct another study of Pennhurst State School and Hospital for the Epilepsy Foundation?

A. I did conduct a study for the Epilepsy Foundation of America, which is located here in Philadelphia. I think it is called the Southeastern Pennsylvania Chapter.

The Epilepsy Foundation was doing a study of Pennhurst in order to develop a model of deinstitutionalization.

As you know, the funding streams nowadays are for the developmental disabilities, meaning mental retardation, cerebral palsy, and epilepsy.

Epilepsy is a very serious social problem in our society which is seriously neglected and the Epilepsy Foundation is very anxious to develop a form of consciousness toward the problem and particularly to do something about all the people at Pennhurst who are not receiving the care they need.

[13-132] Do you want to stop me?

Q. I wanted to ask what portion of the approximately 1254 residents at Pennhurst have epilepsy.

A. There are over 300. At the time of this study I think we figured about twenty-six percent, around 330 people who have had, do have, or there is a very, very good possibility that they will have seizures because of the various clinical pictures.

About twenty-six percent of the population, we figured. That is an estimate.

Let's put it this way — we identified 330 people who are receiving medication for epilepsy.

Q. Will you describe to the Court first the time during which this study was conducted, the design and conduct of it, and your conclusions?

A. Okay.

I was responsible for one portion of the study. It is a complex study which is being done on an interdisciplinary basis.

I was responsible for interviewing fifty people at Pennhurst who were receiving medication —

THE COURT: May I interrupt?

BY THE COURT:

Q. This is in connection with your prior study?

A. Yes. I am now describing the Epilepsy Foundation Study.

[13-133] Q. Very good.

A. I was responsible for interviewing fifty people who were receiving medication for seizures. I was able to interview thirty-eight of them.

I conducted the study in the months of December and January.

My job was to read the records and make some judgments about these people.

What I designed was a study that had three parts to it. I would first read the record, then I would interview the client, and then I would make certain judgments, and here are the judgements I made:

How ready is the individual to leave Pennhurst?

The second judgment is how much has Pennhurst readied the person to leave Pennhurst?

Third, how much community readiness has been developed so that the person could leave Pennhurst?

Then I developed a very fancy sort of rating scale on all three in order to reduce the subjective data into something that would be quantifiable.

BY MR. GILHOOL:

Q. And what were your findings and conclusions from this inquiry?

A. There were a whole string of findings. Let me just hit a few highlights. Okay?

What we found, one of the most intriguing re-
[13-134] sults of the study, one that I hope to continue at a later date, is that no matter how retarded a person is — I reviewed people who were profoundly-retarded, severely-retarded, moderately-retarded, and mild.

No matter how retarded the person is he has an acute awareness of the fact that he has seizures and I took from that recult the very strong realization that no matter how retarded a person is he experiences; he knows what he is experiencing, and he is very sensitive to his own experience.

Having a seizure is a very special kind of peak experience that a person has. Fortunately, not everybody has them.

That was a very important result.

What I also discovered was that epilepsy was not being given such acute attention by either the staff of Pennhurst or by the community.

I found that my rating of readiness of the residents was much higher — was slightly higher than the ratings of the Pennhurst staff, but very, very much higher than the ratings of the community.

In effect, what I am saying is that the communities were doing nothing to help these people leave Pennhurst. They simply are not tuned in to the needs of people.

Q. When you say "communities", what do you mean?

A. BSUs.

[13-135] Q. Base service units located where?
A. Well, let's see. I think most of the base service units that Pennhurst has people from are in the five-county area, so that most of them are from the five-county area.

I should have mentioned earlier in the Pennhurst study for the State we did also samples of the BSUs and the counties' mental-retardation directors.

Maybe some of the others could give you the results on those.

But coming back to the epilepsy studies what we found is that the BSUs were not tuned in, not receptive to the needs of seizures, and not doing anything to get ready to discharge these people.
Q. And by "these people" you mean the residents of Pennhurst?
A. These were the thirty-eight residents of Pennhurst who were having seizures or were given anticonvulsant medication.
Q. Was that finding in the epilepsy study of the base service units in activities for preparation consonant with the study of the findings done by you and your colleagues at Pennhurst?
A. Well, essentially, the findings in both studies would be similar.

Pennhurst does not push the BSUs to develop programs. The BSUs do not push themselves to develop programs.

The county administrators seem to be allowing Pennhurst to die of attrition. They seriously do not
[13-136] give it attention.

There is a lack of camaraderie and there is a lack of — I shouldn't say camaraderie. There is a serious lack of interested partnerships between the BSUs and Pennhurst.

There is a great deal of confusion about the role a BSU should take when it has a resident living at Pennhurst, many, many confusions about it.

They don't know whether they should be parents, advocates, or visit or treat or whay they should do, so there is much confusion.

As a result, what happens is that the people at Pennhurst feel very put upon and very angry at the BSUs for good reason because people are sent there, simply dumped, and then Pennhurst is left to treat them on their own.

The people in the BSUs feel overwhelmed by the need for service in the community, so they put the people at Pennhurst on the bottom of their priority ladder, so what you get is a picture where each is missing the other and it is a system which is not working.

We also discovered that there were $18 million missing.

Q. Would you speak to that, please?

A. Well, in our study we found that there were $21 million allocated to community funding and we saw evidence of about three or four million spent.

[13-137] But we couldn't find out what happened to the rest of it. I know I don't have it because I haven't gotten paid yet.

Q. Dr. Hersh, based upon your work in the course of both of these studies, in your opinion is Pennhurst the least restrictive environment possible for the care and habilitation of its residents?

A. I would just answer that by saying that it is the most restrictive environment.

Q. Is that true for each of Pennhurst's residents?

A. Each of Pennhurst's residents.

* * *

Q. On the same basis, have you an opinion, Dr. Hersh, is Pennhurst the least separate environment possible for the delivery of care and habilitation for Pennhurst's residents?

A. No. I think it is the most restrictive. What it does is that it takes people out of their normal — an opportunity for some normalized existence — and segregates them and moves them to a location which is so far from their families that it literally disrupts normal family relationships.

Q. Does your opinion in that regard with respect to the least restrictive and the least separate, obtain for
[13-138] each one of Pennhurst's residents?

* * *

THE WITNESS: I think what you do is you believe in a couple of things.

First of all, you believe in what you see. We observed Pennhurst for hours and hours and hours and hours and hours. We saw a lot that was good. We saw some lovely programs, we saw some dedicated people, but we didn't see enough of them.

We saw a lot of people sitting and milling, who were badly dehumanized, and some people who had become very troubled people as a result.

Number 1, you believe in observation; and,
[13-139] Number 2, you believe in random sampling.

If you evaluate very carefully a sample you assume that that sample represents the whole to that extent, so that I would have to say that for the most part it is not a very conducive setting.

I hope you understood my qualification when I said that there were some good programs there. There are just not enough of them and I don't think it is possible that there ever will be.

By MR. GILHOOL:

Q. Did you see anyone in Pennhurst in forming your opinion for whom it is necessary because of his

handicap or her handicap that care and treatment be provided in such a separate and restrictive environment?

A. I can answer that by way of showing you the conflict that arises in a person when you go to a place like Pennhurst.

After spending several weeks there, one night I couldn't sleep and my wife asked me what the trouble was. I said that for the first time in my life I had allowed myself to examine what the meaning of euthanasia was, that up until that time in life I had always pushed away that question, that I couldn't bear to think about euthanasia and as a result of spending a lot of time at Pennhurst I one day or one night asked myself wouldn't these people be better off dead because this is really not an existence.

[13-140] Q. How did you answer that question?

A. Well, I don't believe in euthanasia except for maybe somebody who has cancer and is ninety-five years old and knows they are dying and has set up a kind of living will and he knows what is happening.

I certainly don't believe in it for people who are mentally-retarded. I believe there are lots of mentally-retarded people, but it was a very painful kind of thing to experience at that study.

I would have to add another slight qualification, and that is that I would find it very, very hard to move some of those folks out there who have been there for forty years and are in their seventies and eighties. It really wouldn't be very fair to move them, but they are a very small percentage.

But I would not like to see anybody admitted to Pennhurst any more, which is my way of answering your question, if that is acceptable to you.

MR. GILHOOL: I have no further questions.

* * *

[13-154] BY MR. WATKINS:

Q. Doctor, is it fair to state that your position is that institutions the approximate size of Pennhurst, the age of Pennhurst, and so forth *per se*, can't do the job that they are set up to do?

A. I think there is no question about it. That was my earlier testimony, that I felt that way.

Q. And how long have you held that view?

A. I hold it more today than I did in December of '76.

I found myself remarkably open at the beginning of December. When I took the job I was willing

[13-155] to give it a fair shake.

I became more and more concerned as the study progressed. I also visited some other institutions just to test out my own objectivity.

* * *

[13-158] BY MR. SACKS:

Q. In your testimony you have made a couple of allusions to the BSUs. In fact, I think you said Pennhurst doesn't push the BSUs.

I'd like to know what kind of study you made and when and where, in your concern with the BSUs.

A. As part of our study, what we did was to take a random sample of the BSUs in the five-county area and we established what we called a standardized outline and we, by way of telephone, called the BSUs and conducted the telephone interviews.

The interviews lasted a half hour to forty-five minutes. They were free-flowing with some degree of focus on questions like how many people have you placed at Pennhurst? How many people are you now responsible for at Pennhurst? What is the na-

ture of your relationship? What do you see as your role in relation to admissions, ongoing, and discharge — questions like that.

The results were fairly clear. The people in the BSUs were more than willing to give us any information we wanted. They had been alerted to our phone calls by Dr. Rice, so that they were perfectly willing to discuss this with us.

[13-159] Q. And there was no face-to-face confrontation and your questions were more or less generalized, nothing specific?

A. No, no, but we did have access to records and in our interviews at the units we were always able to cross-validate by reading records and seeing how much contact the BSUs had; and we were also able to talk to the staff of the units to assess how many visits and how much contact there had been, so we had a replicating process.

Q. Did your questions with the BSUs involve the life-management plan that the BSUs developed for each resident at Pennhurst and how often they update this?

A. Yes. That was one of the questions.

Q. And what was your more or less general response? Do you remember that offhand?

A. The BSU response?

Q. Yes, to the life-management plan.

A. Yes. The life-management plan for the most part is *pro forma*. They just go out there and they run through a life-management plan, or what they are more apt to do is to utilize the Pennhurst reports to fill out their own life-management plan form, so they are just going through the motions.

* * *

Testimony of Valaida Walker

* * *

[14-5] Q. Were you in the courtroom yesterday and did you hear Dr. Hersh's testimony with respect to the four focal questions of your inquiry?
A. Yes, I did.
Q. Did you and do you join in his statement of your answers to those four focal questions?
A. Yes, I do.
Q. Will you tell us, please, what were the conclusions of your study and, in particular, what were the recommendations to which you and your colleagues came?
A. Okay.

We, unfortunately, didn't have our notes and what we did was the three of us got together and recalled as much as we could our recommendations, so they may vary a little bit from the content of the report, but they are our recommendations at this point anyhow.

The first recommendation would be that there be no new admissions to Pennhurst.

If I may, I'd like to speak to each one of the recommendations.

[14-6] Q. Continue.
A. As you know, some years ago commitments were stopped, admissions were stopped at Pennhurst, but the courts continued to court-commit people and we felt there had to be a mechanism where the court could not commit anyone to Pennhurst any longer.

The second recommendation was that no additional funds be spent in Pennhurst. We recognize that there are a lot of — there is a need for additional staff and that Pennhurst has requested additional staff to bring the standards up as far as medical as-

sistance and also JCAH, and also that there are additional renovations needed to bring it up to late life-safety codes.

But we are recommending that none of these funds be spent because our third recommendation is that all of the residents from Pennhurst be discharged to the base service unit and that money spent to upgrade the programs and to upgrade the buildings would just be money down the drain.

Our major recommendation is that all of the residents be discharged back to the base service unit and that there be a mechanism in the community to service them. We feel that legislative modification must be made to allow funds to follow the residents into the community.

In other words, right now the system is such that Pennhurst, as an institution, gets the funds and there must be some sort of mechanism for funds to
[14-7] go from the institution into the community and follow the residents.

We also are recommending that along with this, in addition to our concern for the future of the 1200 residents in Pennhurst, we have a great deal of concern for the staff that is there too. There are 1700 employees there and just, you know, to send all of the residents back into the community and leave no jobs for the employees is quite — is something that if you have a human touch you have to be concerned about.

So another recommendation we have is that there should be some provision made at the State level to permit the State employees to transfer to the base service unit and community without any loss of benefits and with their same status.

The fourth recommendation was that the New Horizons Building and the modular buildings on Pennhurst be donated to Chester County to be used

for their community services, such as drug abuse, alcohol, or whatever; but that they no longer be just mental-retardation facilities, but that they have access to the buildings and can use those to develop programs in them as they see fit, and that the remainder of the buildings be turned over — either be demolished completely or that they be turned over to some community group, such as a community college, or office buildings, so that they are not used or can never be used for an institution again.

The sixth recommendation is that the name of
[14-8] Pennhurst be abolished completely and never be attached to any part of the facility whatsoever for obvious reasons.

THE COURT: May I interrupt to ask you a question?

BY THE COURT:

Q. I believe one of your recommendations is that all of the residents be transferred to some community-based unit.

If I remember correctly, and I may be wrong, Dr. Hersh yesterday, I believe, when he made a similar recommendation, said something like except those older people — I don't know exactly how he put it.

A. He did.

Q. I just wondered how you felt about that because I notice that your recommendation is that everyone be transferred to some community service.

Do you, yourself, see any reason why some of the older residents couldn't find happiness in the community?

A. No, I don't, Judge, and I disagree with Dr. Hersh on that point.

Q. That's very interesting now because you said you agreed on all your recommendations, but they

always say that that's somebody's prerogative — to disagree. I don't know.

A. Well, the recommendations are consensus, but within each one of us we came to a point on which we agreed.

Q. On the major recommendations?

[14-9] A. Yes.

Q. I realize that. All right.

You do think then that the community somehow or other should, in your opinion, absorb these older residents?

A. Yes, I do. Yes, I do.

Q. I was lucky enough to be raised in a small suburban community where before normalization came in vogue they practiced it.

I can remember going to the corner grocery store and seeing a non-verbal, profoundly and seriously-retarded youngster helping in the grocery store.

I can remember in school there being a janitor's helper and everybody knew you didn't take notice to Ernest because Ernest couldn't read and it wasn't until later that I realized that Ernest was mentally-retarded.

But, as I look back on it, many of our people were absorbed in the community and they were part of the community.

Now maybe a suburban community is atypical, but I can cite an example of where I live. I pass a corner where there are five buses that intersection and during the summer a group of mentally-retarded individuals move into a foster home in the neighborhood and I was rather worried because I would see them standing on the corner waiting for the bus every day and having taught school and

[14-10] knowing how school kids can be, I wonder, when

school comes, are the kids going to tease them and I would drive by.

For a couple of days they would look at them very strangely and oddly, but within a month it was very interesting because they are holding umbrellas for each other and they were totally a part of that bus crowd and they were integrated and these were older people.

I learned later that some of them had been removed from Pennhurst and were living in a foster home in the community, so I am not thinking it can work, I have seen it work and I am convinced that it can.

BY MR. GILHOOL:

Q. Dr. Walker, similar recommendations to replace Pennhurst with community services have been made as long ago as 1970, have they not?

A. Yes, they have.

Q. And, indeed, as long ago as 1970 some $21 million were available precisely for that purpose?

A. Yes.

Q. In your opinion, based both upon the recently-completed study of Pennhurst and your experience otherwise with the mental-retardation system or non-system in Southeastern Pennsylvania, why, at the bottom line, has this not happened?

A. Okay. Well, I think that there are three parts there, I think there are three aspects.

[14-11] I have really given this a lot of thought and I think that the system is very much to blame. The duality of the system which allows the State — and the law is very clear in the Mental Health — Mental Retardation Act — that the State is responsible both for institutions a hundred percent and the community is responsible for one aspect.

But the funding has not been equal at all, so the duality of the system creates problems and also pro-

vides no incentive for the communities to develop any kind of facilities. It is easier for the community to commit somebody to an institution than to try to develop a community situation itself.

Secondly, I don't think there is any clearcut responsibility. In having been a regional commissioner I remember reviewing the budget of counties and not really having any responsibility to make sure that they were followed through on their suggestions, which leads to the next problem of the political implications of the system, where counties' base service units would contact people at higher levels, even on the political and legislative spheres, to undermine the kinds of things that were being done at the higher level.

I think one of the problems — and as long as I have been in the system I have never known an institution to close — as soon as they talk about or they begin to uncover horror stories in any kind of institution it is quickly covered up and unions begin to fight for their turf.

[14-12] It is really not the residents that are involved at all. It is the constituents of a legislator who put pressure or constituents of legislators or unions moving to force the continuance of a very, very bad system.

So I think that one of the recommendations that we made of transferring labor to the community might avoid such a situation in the future.

Q. Has such a plan for assuring jobs in the community, indeed identifying which jobs they shall be and arranging the transfer, ever been put together by the Commonwealth?

A. I can remember when I was in the department we suggested it, but there was never any plan and the suggestion was laughed at as really not being enforceable or becoming a reality.

I think that Pennhurst is somewhat to blame because of the same job stability, the continuance of status. Everyone is afraid to really accept change.

When I look at the philosophy of Pennhurst, it says that it is temporary placement.

Q. By "philosophy" do you mean that written one-and-a-half-page statement?

A. Yes. It is to be temporary placement; but, in fact, because of the staffing pattern, because of the lack of staff and all of the other kinds of things — and I have to hasten to add that we saw many, many dedicated staff, but the system really does not allow for
[14-13] staff to train the residents for temporary placement with the flowback into the community, so I think that there is a survival mechanism that certainly is a psychological survival mechanism that some of the staff need to have.

Worst off is the counties and the base service units and I also have to hasten to add that I am sympathetic with some of the problems of the base services units the counties have and I feel that many of them have done a better job than others.

I think that there has been a lack of trust, and again I am speaking from experience. I can remember in 1973, when the Family Services Resources funds were made available to the counties. The counties were very reluctant to use them for the units. A lot of it was turned back to the Department of Public Welfare at the State level and in my position as regional commissioner I was pushing people to use these funds.

Q. What were those funds? What was the Family Resources funds?

A. Well, they were used — as Mrs. Bowman testified what she needs is a babysitter sometimes and she would not like to have her daughter institutionalized, but the strain of having someone to be home

all the time, every day, and never being able to go out like a normal family, is very hard.

So the Family Services Resources funds were made available to provide such services — transportation, babysitter services, and whathaveyou — and the base service units in the counties were reluctant
[14-14] to use this because in the past the State has developed programs, given money, and then taken the money back and then the county and the base service units have begun to provide a service and then are left high and dry and are the bad guys in the situation.

So we, you know, had difficulty in selling them the idea. In many cases what also happens is that restrictions are put on the use of the money and the counties and the base service units don't have the discretion that they need to have to provide the kinds of services that are needed on the community level.

I think part of the problem with the base service units is lack of interest. I came into the department in 1972 and it wasn't until 1973 that there was even a commissioner, one person in each region, that was assigned to mental retardation and I don't really want to get on my soapbox, but the whole emphasis has been on mental health and it still continues to be mental health.

There are twenty-seven base service units in this Southeastern Region and there are seven who still carry the name of a mental health unit and don't even include mental retardation in it.

This is symptomatic of their idea that mental health, drug abuse, and alcohol somehow are more popular kinds of things to deal with and mental retardation is less understood and has much more of a
[14-15] stigma attached to it, as they see it; and, therefore, is the stepchild as far as services are concerned.

Q. The base service units receive certain funds which are earmarked for mental retardation, like the Family Resources Service funds; is that correct?
A. Yes — well, the counties receive a budget, which then is divided among the base service units, but they have the discretion of the division of that budget.

The family services, Family Resources Services, is a lump sum that is given to the counties.
Q. But the bulk of the money received by the base service units in the counties is given to the base allocations?
A. Yes, and that goes to personnel rather than services.

THE COURT: May I interrupt and ask a question?

BY THE COURT:

Q. Would you mind telling us on the record what a base service unit is?
A. Okay.
Q. I mean everyone uses that term and —
A. Okay. A base service unit is, according to the Mental Health-Mental Retardation Act there are geographic locations which encompass a population between 175,000 and 200,000 people and that is called a catchment area; and each catchment area of that population must provide a base service unit, which provides certain services to the residents in that catchment area.

[14-16] Some of those services are diagnostic, evaluation, referral, emergencies.
Q. Are these boundary lines for the base service units contiguous with the counties or do they disregard the counties?
A. In the Southeastern Region of Pennsylvania we are so heavily populated that they are contiguous within counties, so that Bucks would have four base service units; Philadelphia, thirteen if my figures

are correct; Chester would have a number, but in Upstate Pennsylvania, where you would not have 175,000 to 200,000 in one county, one base service unit may include three or four counties.

But this is the nature of our population.

Q. So that if I understand you correctly the base service unit was set up under the Mental Health and Mental Retardation Act?

A. Yes.

Q. And is it funded directly by the Commonwealth or is it funded by the counties?

A. The county puts in some money, but the money flows from the State.

Q. Are the employees of the base service units considered county employees or are they considered State employees?

A. They are considered State employees — county employees, but there are specific guidelines that must be adhered to by the State.

[14-17] Q. You say they are considered county employees?

A. County, county employees.

Q. And the funding of the base service unit, as I understand it, comes directly from the State appropriation?

A. Yes, it does.

Q. Do the counties provide any part of the costs of operation?

A. Yes, they do. Yes, they do.

Q. Do you know what the formula is, if there is one?

A. Well, for some services it is ninety-ten and for some other services the county puts additional money.

Philadelphia County, for instance, I also believe gets additional funds through United Fund and some other kinds of agencies.

Q. All right.

Now I am going to go back and, if you know, did Act 256, which you know, which it has been testified here is the act pursuant to which there was appropriated, I believe $21 million —

A. Yes.

Q. — for the establishment of county facilities to take care of the problems that we have been discussing here in this court.

A. Yes.

Q. If you know, under the mechanism was that money appropriated to the department in Harrisburg or was it appropriated for the use of the base service units or who has control of saying well,

[14-18] here's $21 million, we are going to give $4 million of it to the base service units in Bucks County?

Who gives that, if you know from your experience? I see that you had participated in government and if you know from that standpoint.

A. The office of the Department of Public Welfare in Harrisburg was responsible for the allocation of that money for the Southeastern Region. The region did approve — we sat down with the counties and helped them allocate how much will go to each of the counties based on the population and their needs in returning people to Pennhurst.

That allocation was made and the counties were then to determine how they would use the money. One of the steps was that they would have a public hearing and that the public would help them decide what kinds of services were to be provided for that dollar amount.

Q. So, in effect, the use and allocation of the money was in the hands of the Department of Health and Welfare?

A. The Department of Public Welfare.

Q. The Department of Public Welfare?

A. Yes, but the counties and the base service units, after it was determined what amount they had, had

to go out and secure the building and then get approval from the Department of Public Welfare.

So a great — a lot of the problem was that there
[14-19] was again apathy in the base service units for finding properties.

I remember during my term of office as Commissioner of Mental Retardation that it was very, very difficult to get the counties out to look at places for group homes, to really decide what their needs were, and to really go about the business of finding community placements.

Of course, it is my opinion that it was much easier to continue to admit them to Pennhurst than to go into community-based services.

The record reflects that in 1970 this money was allocated. It is 1977 and we still are not nearly off the ground in terms of services.

The records also reflect that the number of people, the places, the slots that are going to be in the community are 2,000 and that if you empty Pennhurst there would certainly be day kinds of services and support services available for every person put back in the community.

BY MR. GILHOOL:

Q. Dr. Walker, Dr. Hersh spoke yesterday of ships passing in the night and you have just testified to the failure to locate in any single person or office the responsibility and the power to get it done, to replace Pennhurst with community services.

A. Yes.

Q. What, if you will forgive the redundancy role, has that failure of identifying responsibility played
[14-20] in the failure to accomplish the objectives and the plans set seven years ago?

A. Well, as Dr. Hersh said, it is like ships passing through the night. No one has any responsibility.

You say in accounting here you have X number of dollars for group homes, you have it here, please get going.

That's all you were saying — please get going. If they don't get going you would turn back that money and you might have people who need services who don't have services available.

One of the problems also, and I still think it exists, was that group homes and community-living arrangements in the beginning everyone wanted to plan programs for the nice, mildly-handicapped individual who probably shouldn't have been in an institution anyhow and really didn't intend to provide community services for the severely and profoundly and the moderately-impaired.

The community has to gear itself up to being able to accept some of its problems and not feeling that a person who has a behavioral problem must be institutionalized.

You know, from my experience in teaching and in a variety of things there are lots of kids that have behavioral problems, that once they have a problem don't get shoved away in an institution, and we have to learn that mentally-retarded individuals also are going to have behavior problems and we have to learn to cope with it.

[14-21] I know I skirted the question and didn't answer it.

What we really need is authority vested in some individual or individuals and it is my opinion, completely removed from the political system.

Q. Dr. Walker, based upon your recent study and your previous experience with the mental-retardation system in Pennsylvania, in your opinion is Pennhurst the least efficient environment possible for the care and habilitation of these residents?

A. Absolutely not.

Q. Is it the least separate environment in which appropriate and effective services can be provided for the mentally-retarded?
A. Absolutely not.
Q. Is there anyone at Pennhurst who would not benefit from services provided in a more integrated community setting.
A. It is my opinion that all — all residents at Pennhurst could profit from a more integrated normalized setting in the community.

* * *

[14-33] BY THE COURT:
Q. Do you have any opinion right now?
A. [MS. WALKER] Do I have an opinion?
Q. As to how long it would take to move everyone at Pennhurst who is a resident to the type of facility in the community which would be most beneficial to that individual?
A. Your Honor, I think if you had someone who was responsible for the movement and saw to it that it was implemented, that it would not take more than a couple of years to accomplish.
That's my opinion.
THE COURT: You may proceed.

* * *

Testimony of K. Thurman

[14-56] Were you in the courtroom and did you hear Dr. Hersh's testimony as to the four focal questions of the study's inquiry and the study's answers to those questions?

A. Yes, I did.

Q. Did you and do you share in those answers?

A. Yes, I do.

Q. Were you in the courtroom and did you hear Dr. Walker's testimony as to the six recommendations from the study?

A. Yes.

Q. Did you and do you join in those recommendations?

A. Essentially, I do, yes.

I would probably make certain modifications of certain issues; but essentially, yes.

Q. Let me ask you, if I may, to describe the findings of the study as a whole, first with respect to the physical and psychological environment of Pennhurst State School and Hospital; and, second, with respect to habilitation or not at Pennhurst State School and Hospital?

A. Yes.

Well, in terms of physical and psychological environment, I think what we find at Pennhurst is

[14-57] something that we find fairly typically at any large residential facility serving a handicapped population, that is, we find many dehumanizing sorts of conditions, and I might list a few of the more apparent ones.

For example, we find open bathroom stalls repeatedly as we go on every ward. This is not something that's unique to one ward, but rather common in every ward.

Bathroom facilities.

We find lack of toilet tissue throughout the institution. In some cases and in some areas we found

feces smeared all over the toilets and in the walls of the stall.

We entered one ward, for example, one evening and all three of us were on this particular unit or actually ward, to find a number of middle-aged and rather elderly gentlemen sitting in a series of potty chairs right out in the middle of the ward, with urine spilled on the floor, I would assume for some of the gentlemen who didn't quite make it to the chairs in time and so forth.

On this same ward, another instance of a very dehumanizing sort of situation, we found a gentleman lying on the floor who had apparently fallen out of a wheelchair. We were in this ward at approximately 7:15, 7:30 in the evening, somewhere in that time range, and we found this gentleman lying on the floor and walked up to him and asked him how long he had been lying there and he said well, since before dinner.

* * *

[14-58] THE WITNESS: We lifted this gentleman into — back into his wheelchair physically, the three of us, and proceeded at that point out of the ward.

Other instances of what I would call dehumanizing conditions would include on several instances where I visited woman's wards. They had nowhere where they could undress without me viewing them and I was invited back on one of the wards to one of these dormitories and found several women sitting, either partially clothed or naked, on their beds, and yet I was invited to kind of come in and walk through and just generally do whatever I wanted to do in terms of my own observing.

[14-59] In terms of other kinds of physical and psychological conditions, and I really, in a sense, have a difficult time separating those two, we found on another ward — what I am trying to report to you now are specific things which I personally observed.

I think that there can be other things which Dr. Walker and Dr. Hersh could have added.

BY MR. GILHOOL:

Q. Please feel free to state the findings of the report as a whole, and let me say that I am correct, am I not, that the three of you, pursuing your individual and joint assignments, then shared your information?

A. Sure.

Q. And together prepared the findings of the study as a whole?

A. Yes.

Q. And these recommendations.

If that's correct, then please feel free to state your findings, the findings of the study as a whole with respect to the physical and psychological environment.

A. Okay.

At a more general level we found Pennhurst to be an inhumane place to live and found really, in our opinion, no way that we could see to ever make it an adequate place to live.

In terms of programming, and we had some debate about this simply because some of the things
[14-60] which are defined as programs we professionally would question whether or not one would consider that a program.

For example, some of the residents who had run through various behavior-modification programs to learn dressing skills or tooth-brushing skills, were then considered to still be on what was considered a maintenance program because some ward attendant would come in in the morning and check off the fact that that person had or had not brushed his or her teeth.

Professionally, as a special educator, I have a difficult time calling that a program.

The reason I am bringing up this issue is even

including that kind of time as programmatic time, in other words, taking anything that Pennhurst referred to as a program, one of our findings is that at best, at the very best, and I think this is a high estimate, the residents are getting somewhere in the vicinity of forty-five minutes to an hour's program time a day on the average.

I found no one, except those children who attended the Chester County Intermediate Unit, who received more than about three and a half to four hours of programming a day. But this was not, certainly not, the average.

If you would factor out several kinds of programs which we would consider not really programmatic in the truest sense of the word, we were probably talking about something closer to a fifteen-minute average per day.

[14-61] In terms of the quality of programs, I think that some of the programs are quite good in theory in terms of what they are trying to do.

However, they don't have the staff. More specifically, they don't have the staff-to-resident ratios that they need to properly carry out those kinds of responsibilities.

In terms of physical environment our findings were in general that the buildings, while most of them I have to say were relatively clean, they were very stark in appearance, very little decoration on most of the buildings.

In some cases we had people eating, sleeping, and recreating in essentially what was the same room, which was a room which was divided by, you know, rather inefficient partitions.

In other cases we had people milling about in what was considered kind of the day-room area and essentially locked out of their own bedrooms because of various kinds of regulations or policies which required that that be done.

We also had buildings, a number of buildings, where supervision, because of the physical layout of the building, was essentially impossible.

One ward in particular that I visited, for example, and I will give this as an example, was an L-shaped ward, where at this end of the L is where the day room and the television are, which is the most
[14-62] common activity that one finds in any mental-retardation facility. They were located there and there is where most of the residents tended to congregate with the ward attendant, right here.

At this corner of the L was where the office was, so that if someone entered the office, that is, a staff person entered the office, they literally could not see down that hallway.

In addition, coming down the other arm of the L were bedrooms, which meant that if one or two of the boys on this unit went back to the bedrooms for privacy or for whatever other reason, they were essentially — there was essentially no way that they could be observed or monitored in any meaningful fashion by the staff either from the office or from the other end of the ward at the day-room end of the unit.

Again, this is an example, but the environments in general were large dormitory-type of arrangements with anywhere from fifteen to thirty residents per dormitory unit, with rows of beds to which individual residents were assigned.

Typically then there was a day room and some type of eating and/or recreation area.

There were exceptions to that.

Q. Given the physical and psychological environment that you found, did you make findings about the quality of the interaction between residents and staff?

A. Well, the quality of interaction in general, be-
[14-63] cause of the numbers of people that are trying to be

dealt with, cannot be very great quantitatively, and I stress quantitatively because if you put one person with thirty other people, and this is probably as true in a first-grade classroom as it is in a mental-retardation institution, and it becomes difficult to individualize attention.

However, with the retarded populations that we are talking about we need actually more individualized kinds of attention and input.

Qualitatively, I think that a number of staff interactions, which showed on the part of the staff, I think, a real care and a real dedication and a real desire to try to do something for these people who they were in charge of.

I think it is a quantity kind of thing and in some cases a qualitative kind of thing; but generally I have to reiterate my colleagues and say I think most of the staff that I came in contact with were dedicated, caring people, but were overwhelmed in a sense with the tasks created by the institutional structures and systems.

Q. Did you make any findings with respect to the growth of residents or their regression?

A. Well, not specifically in terms of regression.

We did look, however, at program plans for every individual and tried to determine from these the adequacy of the plan for habilitative purposes and
[14-64] our findings in general were that the plans were so nondescript and general in nature that one could easily infer that given this plan it is doubtful that there would be much in the way of progress towards the kind of specific goal.

For example, one annual program review goal that I read was for So-and-so to reach his maximum potential.

Well, that, essentially, says nothing in terms of what we are going to do programmatically for an individual.

It would seem to me that the basic underlying philosophy of any educational and habilitative program would be to bring whoever was benefiting from that program to his or her maximum level of potential.

I found it very difficult in the record that I looked at to assess progress primarily because some notable exceptions became implemented by the DAPT team.

There is no systematic way of that being used. I shouldn't say there is no systematic way. There is no systematic way it can be employed to measure ongoing progress in the residents.

That, coupled with the rather nondescript and general kinds of goals that you tend to find in annual program reviews, would lead one to believe that most people were not making much in the way of definitive progress towards goals.

Q. Let me recite three findings which are in evidence in the record before this Court and ask if your own study is consistent with these findings.

* * *

[14-65] I am referring to the testimony of Dr. Betty Hare and Dr. Flueck and the exhibits that were received therein.

My first reference is to PARC Exhibit 53, Table IV, which shows that upon a review of a one-in-ten sample of records of Pennhurst residents, in thirty-four percent of those records there were explicit affirmative notations of record on the part of the residents in skill and performance, but second, and perhaps my colleagues can provide the exhibit table citation, for Mr. Goldberg, the second finding was an absolute diminishment in social age score on the Vineland for nearly fifty percent of the residents at Pennhurst who had two Vinelands over a period of time, and the third was for eighty-seven percent of

the residents a drop in social quotient between Vinelands.

BY MR. GILHOOL:

Q. Now are those findings consistent with the findings of your own study?

A. I would say yes, they would be, but I must
[14-66] qualify it by saying that we did not look at those reports for Point A and Point B in terms of a score as a specific score on a Vineland or other scales of adaptive behavior.

* * *

Testimony of Elsie Schmidt

[14-107] Q. Mrs. Schmidt, you are the president of the Pennsylvania Association for Retarded Citizens?

A. Yes.

Q. And you have been president since 1975?

A. Correct.

Q. Will you tell us when your activities with the Pennylvania Association began and what positions of responsibility you have occupied in the organization?

A. My position with the PARC began six years ago when I went to the Executive Committee of PARC. I have been on the Executive Committee for six years.

In 1972 I was given the charge of chairperson of the Education Committee to sustain the implementation of the right to education.

I then served as one of their regional vice-presidents, served as a senior vice-president; and then, in '75, took the presidency.

I have also, on a local level, served as a local chapter president. I have served for four years on the local MH and MR Advisory Board in the capacity of vice-chairman, chairman of the Planning Committee, and have served on the Evaluation Committee.

Q. Is that the Board of Westmoreland County?

A. Yes, sir, and I have also been and I am also a member of the Board of Trustees of the Ebensburg State Center.

[14-108] Q. When did the Pennsylvania Association's attention to Pennhurst originate?

A. I think it is a fair statement to say that there has never really been a time in past history when the focused attention has not been on the quality of life at Pennhurst.

As a matter of fact, PARC was founded right here in Philadelphia in 1950. The early leadership and members of the organization were parents of children who resided at Pennhurst. They were concerned with the kind of care and service they received.

I am the thirteenth president of PARC and all the other presidents have been concerned with the quality of the care at Pennhurst.

Now, twenty-seven years later, I am still to be concerned with the establishment of a full array of community services as alternatives in lieu of placement of persons at Pennhurst.

Q. Why, Mrs. Schmidt, does the Pennsylvania Association for Retarded Persons exist?

A. Well, generally speaking, we exist to promote the welfare and rights of all mentally-retarded people but if we go back to that early beginning we exist for the purpose of finding a community alternative, the answer to placement in institutions.

We are looking for those alternatives to be funded by public agencies so they can do the job, so
[14-109] that parents will no longer have to be concerned.

We come to this time in the history of our organization, we now see that we are in existence for another reason — to protect the rights of individuals.

We also have the responsibility to monitor what we initially created and hopefully will become a future for our mentally-retarded people.

Q. Around 1967-68 did Pennhurst become a still more intensified focus of attention and activity by the Pennsylvania Association?

A. Yes, it did, sir.

Q. Would you tell me why and the developments around that focus?

A. Well, while we were somewhat successful in establishing community services in the area of educa-

tion and vocational training at the same time, along with our parallel activities, there was still the counsel of professionals who encouraged parents to place their children in institutions.

By 1967, which was only a year after the advent of the MH and MR Act, we were alarmed with the conditions at Pennhurst — overcrowding and understaffing.

I can still remember vividly the incident that brought the Pennsylvania Association for Retarded Citizens — at that time it was Children — to agonize over an incident that I would like to relate, if I may.

* * *

[14-110] BY MR. GILHOOL:

Q. Mrs. Schmidt, would you tell us of the event that gave rise to PARC's intensive activity around Pennhurst in 1967-68 and what followed therefrom?

A. In '67 and '68, the PARC residential chair was chaired by a young lawyer, the father of a child, Dennis Haggerty.

He received a call from a mother who had re-
[14-111] ported to him when she went to visit her child at Pennhurst. She discovered that the child had been dead for three months.

She ran back to the ward where the child lived to find out what had happened and she had been told that her son had died in a fire.

MR. WATKINS: Your Honor, this is hearsay.

MR. GILHOOL: Your Honor, it is not offered for the truth of the story, but rather for what followed therefrom, and I will certainly —

THE COURT: We are taking it as the basis on which certain parents got together and formed an association.

BY MR. GILHOOL:

Q. Did the Pennsylvania Association, following the report of this event, undertake an intensive investigation of Pennhurst?

A. Yes, sir, we did.

Q. And will you tell us of that investigation and of what activity and developments and efforts came out of it?

A. Well, I would say, if I can, that for the first time we got into a little bit of the government work and this investigation because we wanted to look at what were the number of factors that might have contributed to the poor conditions at Pennhurst, what probably might have been the problems.

In the course of that study we discovered that there were a number of things that contributed to the Pennhurst ineffectiveness.

[14-112] The first thing we discovered at that time were the wages paid to attendants. We discovered that they were little more than what was paid to people on public assistance.

So we at that time urged the employees to unionize. We felt that it was time for them to challenge for more wages, it was an opportunity to recruit more-qualified people and also to recruit professionals.

One of the things that we discovered was that there was a law requiring that superintendents of institutions be physicians and psychiatrists. We found in many instances that physicians, those who were eventually recruited in their position as superintendent, often were those physicians who were not able to make it in the community.

Psychiatrists, we discovered, knew little about mental retardation or the whole side of the developmental aspect of the child, so we were able to influence a law change.

We have now heading all of our institutions in Pennsylvania our developmental specialists.

We discovered other things. There were policies and I think it was Mrs. Bowman or one of the other parents who mentioned here in the trial that we were not permitted to visit the back wards where the children slept and ate. We were able to influence a policy change for an open-door policy; the parents may come and go as they felt necessary.

* * *

[14-113] We discovered that there was almost a total absence of programming at that time in '67 and '68. We found out that ninety percent, ninety-eight percent, of the residents at Pennhurst had never had the benefit of educational training.

As a result of that we looked at that problem very, very seriously — what impact could we have on bringing immediate programming to the residents of Pennhurst.

It was the association's choice to seek the right to education for all children. We felt that was the best system and the immediate system that we could tap into to bring results, especially to those children presently residing in institutions and those in the community who had not formally been served or were not being served appropriately.

We went about what perhaps may have been our greatest impact in the way of helping at Pennhurst.

So, in summary, we did numbers of things at that time, hopefully that they would be remedied

and that we could see some improvement at Pennhurst.

Q. Let me focus particularly on act 256, the money and the plans for the replacing of Pennhurst with community services.

[14-114] You have testified that despite the act that has not happened. Why has it not happened and what has PARC sought to do about that fact?

A. Well, we have been distressed over the fact that nothing has happened with the money appropriation from Bill 256. Orginally. it began when the act was passed that we were part of the group in the development of Phase I of the development of the plan to implement the moneys in Act 256.

At the end of 1972 there has been a suggestion of further litigation, negotiation, that we possibly could get that money to be used appropriately; and we had to stress that financially we would not be able to achieve the benefits of that $21 million.

Q. Have you had occasion over the years beginning in 1971-72 to meet with responsible State officials — the Secretary of Welfare, the Governor and the rest — to complain about what's not happening and to make recommendations?

A. My involvement in PARC has caused those kinds of activities beginning from '73, '74, and so on.

We have had numerous meetings with the former Secretary of Welfare, the present, and the Governor in pursuit of those.

Q. And what recommendations have you made over that period of time in those meetings with State officials?

A. Well, our concern, as you know, is to increase
]14-115] community services and we have made numbers of recommendations and, as I mentioned to you, the comments made by Dr. Hersh and Dr. Walker, I would like to inform the Court that every one of

those recommendations in regard to the system, and its ability to perform we have discussed with the previous secretary, the present secretary, and the Governor.

They have all agreed with us, yes, they are problems, they are things that can be corrected through administration changes. They have agreed and promised that they would do them.

However, to date, none of them have taken place.

Q. Will you compare by way of example some of those recommendations that you made to correct the situation?

A. The first one is that there is no one person in authority to implement what needs to be done.

We brought that right out to them and I can give you an example of the inability, the lack of authority.

Within the structure of the Department of Welfare is four regional deputy secretaries and the Eastern Regional Deputy Secretary is Dr. Hobbs.

Underneath him is the Commissioner of MR. The Commissioner of MR reports to the Regional Deputy Secretary.

However, in the office in Harrisburg, in a special office, also is the Deputy Secretary of the Office of Mental Retardation. That secretary is on the
[14-116] same level of the Regional Deputy Secretaries and the Deputy Secretary has no authority or ability to direct the Commisisoner of Mental Retardation.

If I am permitted to say at this time, previously, it has been indicated to us that the Deputy Secretary of the Office of Mental Retardation could develop programs and plans until he was blue in the face and he had no way of knowing whether they were implemented.

We have — PARC in 1974 completed their plan for the design for living for individuals.

One of the recommendations in that plan was that the Deputy Secretary of the Office of Mental Retardation have authority for programmatic planning. It was agreed upon by the present Deputy Secretary of Welfare, Helene Wohlgemuth — at that time his name was Frank Beal —

However, that has not happened and that causes delay.

Q. A further illustration of your recommendations, will you correct me on that?

A. Along with doubt in that area we also knew that the regional state does shape county plans. They form the policy, how programs will be run. They ultimately approve both the plans and the budget.

Usually the process is the county develops its plans and sends them to the region. There the re-

[14-117] gion approves those and upon their approval they go on to the central office and then the central office approves them.

Within both the region and the State they identify the priorities between the two of them. Priorities have been deinstitutionalization, the dispersal of people from such as Pennhurst.

Yet, when you look at the county plans, the county plans do not reflect the priorities and the policies and plans that have been established by the central office.

* * *

[14-118] Q. Is there any place in Pennsylvania where we will say the counties have made more progress than in this five-county area around Philadelphia; and when I say more progress I am talking about establishing beneficial community services for the retarded.

A. There are more services in some counties than there are in others but, generally speaking, I don't know if I would classify any of them as providing adequate services in any way in any one of the counties.

Q. Well, has more progress been made according to your observations in some parts of the state than in other parts?

A. Well, we have — in the western part of the region we do have — we have had movement of people out of our State institutions, where you see a larger development of community-living arrangements in the Western Region.

I believe, if my figures are correct, that the Western Region has the highest number of facilities for community living.

Q. When you say the Western Region, what specific area are you referring to?

A. The twenty-three counties beginning up at the top about Erie and going down to the bottom of the State, in the western part of the state.

Q. And has there been any substantial movement in the deinstitutionalization in that particular area and, if so, from what institutions?

[14-119] A. There has been considerable movement out of Polk, which was the largest institution in the western region. They have decreased their population from close to 3,000 down to 2,000.

Q. Polk is now approximately 2,000 as best you know?

A. That's right; 2,000.

THE COURT: All right.

I just wanted to get a basic idea.

BY MR. GILHOOL:

Q. Are there further recommendations that PARC has made to State officials with respect to shaping the performance at Pennhurst?

A. Right. The one recommendation has been made again and again, beginning in '68, '69, and so on; and that is the requirement for life-management plans.

And according to the new Deputy Secretary of MR, he has once more issued a memorandum that there shall be life-management plans for every resident; but at present they have not existed.

There are several other areas and one is the request for separate budget for accountability. We felt that the central office might have a better handle on what is happening in the area of mental retardation versus what is happening in mental health.

There is the category of funding along those lines also to identified funds.

[14-120] There has been no change. However, there has been agreement that that has been a good suggestion and me might implement it.

Q. What other recommendations has PARC made?

A. Well, the critical one in the course of making all of these recommendations, we ultimately faced the Deputy Secretary who was saying that the law of 1966 provides that if counties are not doing their job you have the right to step in and do it.

And we have requested that on many, many occasions where the counties have failed to move ahead.

We have made several other suggestions and we are very much aware that deinstitutionalization involves the economic question. There is the employment, according to my thinking, of about 22,000 people that will have to either lose their jobs or have to be reemployed in another way.

We have in the beginning requested for retraining, orientation to the tasks ahead. That is incorporated in a number of plans that we have submitted to the Department of Welfare that we felt this was critical.

We see that in many ways the staff and the institution are quite capable, know the people that they have to work with; and if they were moved over to new responsibilities in the community, that we might more effectively deal with the people coming back.

THE COURT: May I interrupt just once more
[14-121] and ask a question?

* * *

Q. You did, did you not, mention the figure of 22,000?
A. That's including all the institutions that we presently have in the Commonwealth.

* * *

[14-127] Q. Mrs. Schmidt, why is it over these many years of PARC's existence and in particular over the last ten years that you have testified to that PARC has sought community services to replace institutions?
A. After being in this room for over three weeks I don't know if I have to add any more to what has already been said.

When I listened to the testimony given by Robert Troester and Robert Hill and Herman Vaughn, I could hardly keep back the tears because that's where it is, that's why we want it.

We heard what it was like living in an institution and we heard what it was like living out.

Mrs. Auerbach, a seventy-seven-year-old mother, thank goodness she saw the day when her son was able to come back and acquire social skills.

That's what we want. Parents want the assurance. They need that; they need to know.

From the early beginning, when our organization first started, that desparate cry for help, co-

counseled each other. We came together, we looked for the day when we could be assured that tomorrow if we are not here somebody else is going to do it maybe even better than we did it.

That's what we need. We need to know that. That's why we think the community is the place. That's where all of us live, grow, develop, and die.

[14-128] It is the best integrated setting that I know. It can happen and we know it can happen. We have done it. We have demonstrated.

Our children were excluded from school and we have got now the most severe and profoundly-retarded children going to school every day. You pass the bus and you see them riding in the bus.

I have known children who stopped having epileptic seizures because they are interested in what is going by when they look out of the bus.

We have made great inroads. We have demonstrated with programs that we never believed that we could do.

We are now pushing for employment in many, many areas. We have achieved it, and it only happens in the community.

I think that's why we want community service, but we have got to have enough of the right kind in the right places at the right time.

* * *

Supreme Court, U. S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and
Hospital, et al.,

Petitioners

v.

Terri Lee Halderman, et al.

Pennsylvania Association for
Retarded Citizens, et al.

and

United States of America,

Respondents

**ON WRITS OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT**

JOINT APPENDIX
VOLUME V, A813-A942

**Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.**

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

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**Qualifications of expert witnesses were stipulated pre-trial. Curriculum vitae designated as PARC and US Exhibits, detailing education, experience, publications and other qualifications of all plaintiffs' witnesses are found in the Final Pre-Trial Order filed at R. 464, March 31, 1978.

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Testimony of C. D. Youngberg

22-118] CLARENCE DUANE YOUNGBERG, having been duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. WATKINS:

Q. Where do you currently reside, Dr. Youngberg?

A. Beg pardon?

Q. Where do you currently reside?

A. 5055 Brown Drive, Spring City, Pennsylvania.

Q. And you are currently employed at Pennhurst Center?

A. Yes, I am.

Q. In what capacity?

A. I am superintendent at Pennhurst.

Q. How long have been so employed?

A. I was appointed superintendent in September of 1972.

MR. WATKINS: By the way, your Honor, there is a lengthy deposition of this witness that has been filed and we will only fill in the gaps.

THE COURT: Yes.

BY MR. WATKINS:

Q. Dr. Youngberg, could you give the Court a general overview of the institution from the perspective of its major divisions, administrative divisions, and living units?

A. Yes. I won't repeat that which has been presented already; I have been making note of it.

22-119] Of course, as we all know, Pennhurst has existed for many years, seventy years, and to bring us up to the present time, it reflects not only a different population but different needs, different services that need to be provided in contrast to many years ago when it was first created.

As we look at the people presently residing at Pennhurst and those who are being admitted or committed in recent months, it seems their needs

also are different from those who came to Pennhurst many years ago.

It seems that in recent months those coming to Pennhurst, their primary need is that of a residential place to live. This is not to say that there aren't other concerns or considerations of programming other aspects and special care needed. That enters in as well, but the primary reason is a place to live.

The task at Pennhurst then is to provide a living environment for the citizen where his basic needs can be met, as well as his other needs, however variable they may be, not only in terms of program needs, but special physical needs.

It is the purpose of Pennhurst to try to meet these needs as best we can with existing resources.

I think it is important to point out too that we start with the conception that for citizens residing at Pennhurst, this should be used as a temporary or interim place. In practice, that has not been the case.

[22-120] We also think or it has been spoken in terms of people living at Pennhurst, getting ready to return to the general community. Here again, in practice, it does seem to work this way, in that when we look at the community placements available, those citizens at Pennhurst who are higher functional, that present relatively fewer concomitant problems, are those more likely to leave; but viewing the overview of Pennhurst, we have to think in terms of the people living there.

It is not a matter of them getting ready to go somewhere else. It is a matter of the general community getting prepared to meet their needs so they can leave whenever this happens, whether it is a week, a month, or many years.

With this in mind then the structured organization that administers the structure in terms of this framework is that the major division of the facility is that of resident life.

* * *

22-128] Q. Now you testified at your deposition, and I believe reference was made to — I am reading an article, I am confused — that you really were shooting or that it was an acceptable goal for you anyway that Pennhurst be ended and people not have to go there some time.

Is that correct? Is that the thrust of your testimony?

A. No, not quite in that context.

I had said I would anticipate and hope for the day when the current need for Pennhurst would
22-129] cease and that people could be served in the community and would not need to come to Pennhurst; that the people living there might be adequately accommodated in the community setting.

* * *

2-149] BY MR. LASKI:

Q. Superintendent Youngberg, you testified on direct examination and I believe in your deposition that mental retardation in and of itself does not require institutionalization and there is a lack of resources in the community to meet the needs of people and that really it is not a matter of you preferring the people to go to the community; it is rather a question of the community preparing to receive the residents of Pennhurst.

Is that a correct statement?

A. That is correct; but that's somewhat taken out of context. There was more to it than that.

Q. Would you want to elaborate on it?

A. Well, as I said, it is not merely a matter of us making a person ready to leave Pennhurst, but we should also and can also take the terms of having the community ready to receive our people back.

[22-150] I had also noted that while people are at Pennhurst, to the extent that their functioning is raised, that their multiple behaviors are decreased or somehow minimized, that increases the probability that they will be able to return to the community because these are where the majority of the community-living opportunities exist for higher-functioning residents that present fewer problems than lower-functioning residents with multiple problems.

Q. Okay.

In that context, though, you did say in your deposition on page 102, I often say it is not a matter of our people getting ready to return; it is a matter of the community getting ready to take their people back?

A. That's correct.

Q. And does that statement apply to all persons at Pennhurst, severe and profound, as well as mild and moderate?

A. Theoretically, yes. Practically, there are problems with that; but theoretically that's correct.

Q. Practically there are some problems with the communities getting ready to take their people back?

A. Correct.

Q. In other words, it will require extra services, different accommodations than it would for other people?

A. At least that.

Q. Is that what you mean when you say practical problems?

[22-151] A. Right. It would take at least that.
Q. Are there any other practical problems that would put that statement in context?
A. It was mentioned earlier in different contexts. It is not only a matter of a place for people to live and all of that; it turns on the degree of supervision they would need and so forth and a program which they can or tend to participate in.

It also involves constructive and other activities for their other waking hours and then a monitoring system to make sure all of this is happening and continues to happen.
Q. And that has to be in the community for severe and profoundly-retarded people to live in the community?
A. Right. The problem is relevant to the community.
Q. We have had throughout the week some people who have testified, either explicitly or have implied, that some severe and profoundly-retarded persons who they knew in Pennhurst could not live in the community and they made distinctions between higher-functioning residents and lower-functioning residents.

Would you say it would be wrong to make that distinction, to say that profoundly-retarded persons, for example, cannot live in the community?
A. There is a great question. I would say it this way — I have found that severely-retarded persons can live in the community.

2-152] BY MR. SACKS:
Q. Repeat that.
A. I have found that profoundly-retarded persons can live in the community.

BY MR. LASKI:
Q. If some persons testified, for example, that there were profoundly-retarded people on Ward 6 at

Pennhurst who did not have the capacity to live in the community, you would disagree with that.

A. I am not certain in what context that statement was made or such statements were made, but it is not a matter of capacity *per se*.

It is a matter of their needs being met in the community or wherever they may reside.

Q. The context was a question. To somebody testifying here the question was or could be are these people who are profoundly-retarded persons — could they live in the community — and certain people answered no, they could not.

Would you agree with that or not agree with it?

A. I can't really agree with the statement because I don't know the context or the point of reference from which they are making that statement.

If they are talking in terms of living in the community with what resources or provisions presently exist, okay, that's one thing.

[22-153] If they are talking about a philosophy or theoretically, that's another thing.

Q. If they were talking in terms of the capacity of the individual —

MR. WATKINS: Your Honor, once again, I think the witness has answered.

THE COURT: Maybe you didn't hear his last answer, but I thought he did answer clearly.

BY THE COURT:

Q. I think you said it wasn't a matter of capacity, but it was a matter of whether or not services were available in the community.

Was that your answer?

A. That's correct.

THE COURT: To take care of them.

All right.

* * *

22-155] BY MR. LASKI:

Q. Even though it is not your view and it is not a true view that profoundly-retarded people do not have the capacity to live in the community, do you find it the commonly-held view by staff at Pennhurst or people who are working in the field in community programs?

A. I don't know that it would be a commonly-held view.

There are people coming from various points of reference, at various points in time.

I think that would be also true of myself. At one point in my life I may have felt that way and at other times not.

I don't know that it would be a commonly-held view. I know there are at least some persons who don't hold the same view as mine and are hesitant about lower-functioning residents being able to live in the community.

But I think it is not so much a matter of that; it is just the overwhelming concern as to whether their needs would be met in the community, and I

22-156] think people are responding to that.

In my comments on the theoretical basis and philosophical basis, I said yes, they can, and should live in the community.

Our difficulty is accomplishing this. I am not attempting to suggest it is impossible.

* * *

2-162] BY MR. LASKI:

Q. Superintendent Youngberg, in your position you participate in a number of planning efforts for institutional reform, deinstitutionalization and depopulation of Pennhurst?

A. Yes, in a variety of planning efforts.

Q. There have been a number of plans developed over the years, have there not?

Q. There have been various plans as well. I think it would be more accurate to say a number of planning efforts, which may or may not have developed into formal plans as such.
Q. In other words, there may have been plans and documents written?
A. Yes.
Q. But they have not come to fruition?
A. (There was no response.)
Q. You heard Mr. Foster testify about the deinstitutionalization and institutional reform plan?
A. Yes.
Q. Basically his testimony was that the deinstitutionalization part did not work too well.
[22-163] A. That was not carried forward.
Q. And is that your experience? You wrote a part of that plan, did you not?
A. No, I did not.
Q. You were superintendent when it was written?
A. Yes, I was.
Q. If it turns out that the officials in Harrisburg, either alone or with your participation, developed another plan to depopulate Pennhurst or to deinstitutionalize residents from Pennhurst and provide services in the community for people from Pennhurst, is there anything changed now that would lead you to believe that that plan might be implemented more readily than plans in the past have been?
A. To be implemented more readily?
Q. Right.
A. I would have no specific reason to believe that, other than in recent weeks and months there seemingly is more consensus that institutions reach into federal office levels as far as service.
Q. The barriers are an obstacle to providing services and the community has not obviously made plans to provide these services; is that correct?

A. Well, that's a difficult question in that the planning that has taken place has been effected in some instances and not yet accomplished in others.

[22-164] Now in that respect, whether that is effective to the plan, I couldn't really say.

Q. Have you been participating in the last few months in any new plans to provide services in the community for the people at Pennhurst?

A. I don't know as there would be any new plans, just a refinement of planning that has gone on for a number of years.

Q. During discovery I recall that the overall plan for meeting Medicaid standards involved reducing the Pennhurst population to 1,000, 1,004 people. That figure stands out in my mind.

Has that been revised? Is that a current plan or is there some new thinking along those lines?

A. I recall during that planning activity we recognized as a result of the life safety code that our rated capacity would be diminished, but then also projecting that the 1977 MA rate would also have implications for us, such as the maximum four beds per room, so we looked at our facility in terms of what that might mean, and that's what came out to a population of 1,004.

So we looked to what changes in resources or modifications would be required to meet that and that's the standard plan.

Now beyond that we were looking to see if there are ways to further reduce population and there is nothing firmed up particularly to my knowledge.

22-165] Q. Have you had discussions about further ways to do that?

A. Oh, yes, discussion for months and months and months.

Q. And who are the primary discussants?

* * *

[22-166] Is that your question, what they are planning now?

MR. LASKI: That's exactly the question and if you want to answer that open-ended, that's what I am interested in.

We have very detailed information, Dr. Youngberg, from your deposition, from Mr. Foster's deposition, and from other depositions.

THE COURT: You are talking about the last couple of months?

MR. LASKI: I want to know what has been happening in April, in the last few weeks, in terms of your plan to provide services in the community for the people at Pennhurst and who has been working on it and what your thinking is.

THE WITNESS: Well, as I noted earlier, it is just a continuation of prior planning, looking for ways to bring ourselves into compliance with Medical Assistance, and an endless process, whether additional resources are needed, whether they can be modified, or whether it is possible to further reduce the population at Pennhurst, not that that is a goal, but to place the citizens in the community, which would result in population reduction.

This would have other implications as far as meeting Medical Assistance.

We had hoped we could get down to a thousand
[22-167] and hope to go beyond that.

The people that are ordinarily involved in this process, certain of the staff, the regional officials, and I would defer to Mr. Rice and his staff and Daniels is involved in the DGS process.

Resident living, nothing new. This has been handled for several years.

At the central office level the Deputy Secretary for Mental Retardation, Mr. Polloni, and his staff, would necessarily be involved in planning, just like Mr. Meyers, his predecessor, was involved in the planning.

BY MR. LASKI:

Q. Your characterization is that there is ongoing planning refinement of your philosophy and plans to carry out basically the intent for community living that the Department and Pennhurst have had for the last five or six years?

A. Well, at least that, consistent with our desire for institutional reform for those that remain at Pennhurst for as long as they remain at Pennhurst, and also those that are able to leave, and what that involves in terms of getting ready resources in the community.

THE COURT: Let me ask a question, if I may.

BY THE COURT:

Q. Do I understand you to be saying that the present overall plan is to reduce the population at Pennhurst to about a thousand?

22-168] A. Well, we hope to go beyond that. First, it was 1250, then a thousand, and it will get lower and lower and eventually four or five hundred or beyond that if we can.

We have looked at figures of 1250, we have looked at figures of 1,000, we have looked at figures of 850, and we have looked at figures below that.

Q. But you consider that all of this is consistent to state that you are presently planning on facilities that will take care of a thousand and also to state that you hope to go considerably beyond that?

A. That's correct; yes.

Q. Do you think that is consistent —

A. Yes.

Q. — planning?

A. Yes. The reason we can't be too specific as far as the future is because much of this depends on resources or budgeting available.

We can talk fairly firmly in terms of existing and what exists now in terms of this fiscal year and carryover.

Q. I am sure you heard the testimony of the plaintiffs and I won't ask you whether you believe it or not, but you heard the testimony of plaintiffs that these services could be provided at a lower cost in the community. Now I want you just to assume for the purpose of this question that this is so, that they could be provided at a lower cost in the community.

[22-169] Then wouldn't the objection to having a larger budget to accommodate this sort of pass by and not be a hurdle to accomplishing, we will say, the depopulation of Pennhurst?

A. I understand there has been testimony that it would be — that it would cost less. I don't know whether that is, in fact, true.

That's a point that I have not yet been convinced of, but that should not be the motivating factor.

Q. Suppose it costs exactly the same. Let's assume for the purpose of my question that it is going to cost exactly the same, whether you take care of the mentally retarded out at Pennhurst or take care of them in the community.

Then do we not eliminate the question of budget and finances in planning for moving the residents of Pennhurst into the community?

A. There would need to be an adjustment in funding mechanisms and the community programs for the most part. At present they are funded through the county and there needs to be a mechanism for providing adequate funding through the county.

Q. What you are saying is that there has to be a mechanism for the State to funnel that money into the counties if you were going to use that amount of budget at Pennhurst, we will say, to help the counties function with their community facilities.

Is that what you are saying, in effect?

[22-170] A. Yes.

Q. Well, we heard testimony here, Doctor, that there are, under Act 256, certain funds provided.

Did you hear that testimony?

A. Not all of that, but I am aware of that.

Q. Are you aware of the fact?

A. Yes.

Q. That at some place in this great Commonwealth there is something like $18 million sitting there waiting to be used for community facilities, or a figure up in that area?

A. I think it is important, though, to recall that this is capital money to acquire and construct facilities and it doesn't really pertain to operational funding; and it was operational funds to which I was referring.

Q. Do you think it would be any different in legislative reaction to a request for $26 million to take care of the retarded residents at Pennhurst if the requests were to come from the counties in connection with the same 1200 retarded individuals?

A. I think it would probably depend on how strongly their constituents express their opinions.

The Legislature would be responsive to others. I don't know.

Q. Let's assume that the people that have testified in this case so far, and that includes, I think, the witnesses produced by plaintiffs and yourself here —

22-171] I think you have expressed a professional opinion, or I should say to be fair with you, that it is theoretically better to provide these services in the community than it is in an institutional setting.

Didn't you say something like that?

A. I was saying it is theoretically possible to do it.

Q. I thought maybe I misunderstood you and I don't want to put any words in your mouth. I thought you were saying it would be better to pro-

vide services such as this in a community setting rather than in an institutional setting.

Did you say that? I don't want to put words in your mouth.

A. I don't know whether I said it exactly that way.

I think it is best for people to be served in a setting most like the normal setting or the mainstream of Society.

This can be done well if the needs can be met, if they are not jeopardized in any way, not suggesting that they would be, but that would be assurance we would want.

Q. As a professional, do you think it would be to the advantage and the benefit of the retarded population of this Commonwealth to be serviced in a community setting or serviced in an institutional setting?

A. Basically, I'd have to say yes, I think it would be —

Q. Yes to community or yes to institution?

[22-172] A. Pardon me, yes to the community, in that I think it is more important to first of all serve people, if possible, in a community setting rather than having a larger residential facility.

I am not willing to say at this time that all people presently living at Pennhurst should be living in the community. That's a very individual decision.

Q. Do I understand your reservation in connection with all people has been based on your observation that there are not community facilities available to take care of all the people in Pennhurst?

A. Not only all, not necessarily all people in terms of numbers, but all people in terms of needs.

Q. Yes.

A. And in addition to that, there are persons at Pennhurst who are certainly resistive to moving from Pennhurst, as we all tend to be resistive to change.

Q. Have you ever had any experience other than at Pennhurst with a relative that was old and didn't want to move out of the old house when the roof was falling in?
A. Certainly.
Q. And where those in the family that were interested had to go and practically carry them to a new and a better location?
A. Yes.
Q. I am just sort of paraphrasing the situation.
A. I am familiar with the situation.
[22-173] Q. In the long run wasn't that move to the advantage of the old person that had been in the old home where the roof was falling in?

Wasn't it better that they be in a safer facility, a healthier environment?
A. Generally so, but it depends. I know persons who have died —
Q. Died because they were moved?
A. No, because of the trauma, because of very resistive people.

There are people who are resistive to a new location.
Q. You know somebody that died because they were moved?
A. Yes, just talking about the trauma of the situation; and I don't wish to imply that that would be true of Pennhurst, but the point I try to make is that it is a very individual and a very personal decision.

I think it is one we want to encourage, to counsel, to have persons who are capable of making decisions and families who are resisting to look at all options available, most certainly those available in the community.
Q. This old person that died, was that a resident of Pennhurst?
A. No, it was not. It was just one of several examples that I recall.

THE COURT: Yes. All right.
I interrupted.
Do you have any further questions?

* * *

[22-184] BY MR. LASKI:

Q. Is there anything in your experience as superintendent in dealing with the budget, in dealing with the appropriations, with the allocations, with the contracts, that would make it impossible to deploy money allocated to Pennhurst to provide services for people in the community, former Pennhurst resi-
[22-185] dents in the community?

A. If there is some reason why this could not be done I am not aware of it. I just don't recall any.

Q. And, in fact, —

A. I don't know of any.

* * *

[22-219] BY MR. PEABODY:

Q. Dr. Youngberg, do I understand correctly from your earlier testimony that the process of deinstitutionalization to be a proper one in your view would be done on an individualized basis so that each individual resident is looked at and placed in a place for that individual's best interests?

[22-220] A. That is true.

Deposition of Clarence Duane Youngberg

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

TERRI LEE HALDERMAN, et al.,
Plaintiff,
UNITED STATES OF AMERICA,
Plaintiff-Intervenor,

v.

PENNHURST STATE SCHOOL AND HOSPITAL, et al.
Defendants.
CIVIL ACTION
NO. 74-1345

Oral deposition of CLARENCE DUANE YOUNGBERG

* * *

[102] DR. YOUNGBERG:

As to the future, we would like to anticipate the day when Pennhurst would not need to exist, that the needs of all citizens with retarded behavior could be met within the community setting. As I said a number of times, it is not mental retardation per se that requires the institution. It is just the lack of alternate resources, whatever they may be in the community, to truly meet the needs of people, including those with retarded behavior.

I often say that it is not a matter of our people getting ready to return. It is a matter of the community getting ready to take their people back. While
[103] they are here, it is certainly our responsibility to do whatever we can to raise their level of functioning, recognizing that opportunities as they do exist tend to be for possible or probable higher functioning residents with fewer accompanying problems. So to that extent, as residents do increase in level function and their behavior level increases, their probability of community return is greater, not because

it should be that way, but that is where opportunities presently exist to a greater degree.

BY MR. THRASHER:

Q. Would you judge that some residents at Pennhurst while they have been here have regressed in their life skill abilities?

A. I don't know that as a fact. We have discussed this from time to time. At least, I have discussed it with other people from time to time. But a person is not able to cite examples where this has occurred. I recognize the possibility exists that it might have.

Q. Are there some conditions here which are consistent in your professional judgment with an expectation that it might occur for some residents?

A. I think such conditions have existed and still exist to some degree.

Q. At Pennhurst?

A. Yes.

Q. Did you finish your statement? I interjected. I
[104] am sorry.

A. Essentially so. That is essentially my statement.

MR. THRASHER: I yield the witness.

BY MR. LASKI:

Q. Dr. Youngberg, do you recall the March 1975 visit of Dr. Jim Clements to Pennhurst?

A. I recall he was here, yes.

Q. Were you the Superintendent at the time of that visit?

A. Yes, I was.

Q. Do you recall preparing any documents in anticipation of the visit of Dr. Clements?

A. I recall preparing documents. I am not sure whether it was for Dr. Clements.

Q. I show you an untitled document which has 32 item entries in it, and ask you whether you prepared that or whether that was prepared under your supervision in March of 1975?

[105] A. Yes. I recall this is the document, yes.
Q. Did you prepare this document?
A. I was involved in the preparation of the final review of the document, yes.
Q. I ask you to turn your attention to Page 4 of the document, Item 32, which is entitled "Recommendations for Improvement Resources by Priority."
A. Yes.
Q. Would you read what is the first priority that is entered under that topic?
A. Yes.
Q. Would you read it for the record, please?
A. "Adequate number of each type of community living arrangements with appropriate 'backup' services to both (a) terminate the need for future commitments to Pennhurst, and (b) provide option to each Pennhurst resident of leaving the institution if he or she so desires."
Q. Does that reflect your judgment of the top priority for Pennhurst residents in March of 1975?
A. To the best of my recollection, yes.
Q. Would you still say that statement or that general premise of adequate number of community living arrangements is still a top priority of residents at Pennhurst today?
A. If you would continue with the phrase "with ap-
[106] propriate backup services," yes.
Q. Is it your judgment that it is a top priority to terminate future commitments to Pennhurst?
A. I would currently perceive it in this fashion, that if the needs of any prospective admission to Pennhurst, if the needs could be met adequately in the community, there would be no need for him to even seek admission to Pennhurst.
Q. Dr. Youngberg, there are three other recommendations for improvements under that topic. Would you please just characterize each of those recommendations? You may read the first sentence

or characterize it. There is no need to read each one. Would you either read or characterize the second recommendation?

A. I would like to read at least the first sentence.

> "2. A safer environment in which each and every Pennhurst citizen would sleep and carry on the activities of his or her waking hours."
>
> This makes reference to the Life Safety Code Project, or in lieu of or until such, at least, the people be relocated to other facilities. That is essentially the heart of it.

Q. Is that still a valid recommendation for improvement today?

[107] A. It is still valid, but to a lesser degree in the context that the Life Safety Code Project is under way. That would reduce the degree of risk or relative unsafety that existed two years ago.

Q. Is it a correct reading of No. 2 that at the time you wrote this you projected the completion of the Life Safety Project within two years, which would be March 1977?

A. That is what it says. So that would be accurate.

Q. That projection was not accurate though, was it?

A. It proved not to be accurate.

Q. If you were making the same projection in terms of completion of the Life Safety Code Project, what would your projection be?

A. I wouldn't be able to project a date.

Q. Would you either again read the first sentence or characterize Recommendation No. 3.

A. "3. Increase complement of 'direct resident contact' staff to adequately meet the needs of each and every citizen residing at Pennhurst."

Q. Is that a valid recommendation for today for residents of Pennhurst?

A. It is still valid in that No. 3, though I made reference to sets of standards with which others are familiar in terms of whether it is valid today, I would still make reference to the standards.

[108] We also base our impressions or projections on needs identified as a result of the multi disciplinary process or policy or the team policies at Pennhurst.

Q. Is it a correct reading that Recommendation No. 3 reflects that you had at that time made budget request proposals to implement that recommendation?

A. Yes, I made such requests in our budget proposal.

Q. To what extent were those requests fulfilled?

A. This was in?

Q. March 1975.

A. It is my recollection that our staffing complement at that point was 1,580. It is presently 1,562. It has been less than 1,562, but it is presently 1,562.

Q. So you had more staff at the time you made this recommendation than you have today?

A. I could check a document.

I guess I don't have it. I am quite certain it was 1,580 at that time.

Q. Recommendation for Improvement No. 4, what does that say and what is the essence of that recommendation?

A. No. 4 was, "Humanely designed and furnished environments in which each and every Pennhurst citizen may live, grow and develop until community facilities and resources are adequate to enable his or her return. Traditional institution environmental

[109] constraints, 'the normalization principle' until community living arrangements exist in sufficient quantity and quality to truly provide an alternative to institutional for all, the environment for traditional institutional structures and operations must be innovatively designed and constructed along

with 'community settings' and consistent with the normalization principle."

Q. I take from your testimony that that recommendation is still valid today?

A. Essentially so, recognizing that there have been improvements in environment and actual living areas exist and are available for the people now that didn't exist at that time. A case in point would be the modular units.

Q. I direct your attention to Page 3 of this document, Item 24, which is entitled "Number of Residents That Should be Discharged."

Would you read your response to that item.

A. It says "Theoretically, all residents could be discharged, given adequate community living arrangements with appropriate back-up services. The question of whether they should becomes an individual decision."

Q. Could you explain for me the meaning of the opening word "Theoretically, all residents could be discharged"?

[110] A. Well, what is intended by that is that given appropriate community-based living arrangements and services, not only in terms of program but activities a person presently living in Pennhurst could also be living in the community. Theoretically, I guess there was some question as to at what point in time this may occur.

Secondly, I made the qualification that if a person does leave Pennhurst, I feel that should be his or her decision, if he is capable of making that decision. The question does arise that if a person has lived at Pennhurst for many years and perhaps has even tried a variety of community placements which have been unsuccessful for one or more reasons, he feels very strongly about living out his or her life at Pennhurst. It becomes a very individual decision. I certainly think counseling is appropriate.

But to say, "You shall move," I would not willingly say that at this point.

Q. In other words, your qualification goes to not impose that on an individual when his choice is to live in a certain environment rather than in another?

A. His choice must be considered. It certainly must be considered.

* * *

[124] Q. Dr. Youngberg, do you recall an article in the Philadelphia Magazine in December 1976 by Loretta Schwartz, which was entitled "The Forgotten Children, Pennsylvania Condemns its Most Helpless Kids to a Living Death"?

A. I am not sure — yes, I recall the article. I think I read it a couple of times.

Q. It is an article about Pennhurst Center.

A. Yes. As best I can fathom from it, yes.

Q. Did you have an opportunity to speak with the author, Miss Schwartz, prior to the publication of that article?

A. Yes, by telephone.

Q. By telephone?

A. Yes.

Q. One time or more than one time?

A. It was, as I recall, one time prior to the article. She had tried apparently to either stop by or to tele-

[125] phone me internally, and I was not able to get back to her until relatively a short period of time before the article went to press.

Q. So you talked to her over the phone?

A. Yes.

Q. And did not meet her personally at all?

A. Not prior to that time. I met her subsequent to that. Subsequent to that there was a photographer at Pennhurst. I believe she was with the photogra-

pher. I am not sure whether I met her then or at a subsequent occasion, but I have seen her in person.
Q. I am going to show you a copy of the Philadelphia Magazine of December 1976, page 225. Would you read the paragraph beginning, "I don't think there should be a Pennhurst."
A. "I don't think there should be a Pennhurst. ('I don't think there should be a Pennhurst,' says Superintendent C. Duane Youngberg. 'In a large residential facility, good care is an almost impossible task.')"
Q. Did you make that statement?
A. No, not in that context nor in that format.
Q. Did you make a statement similar to that?
A. Not with that implied meaning. As best I can recall, there was a fairly lengthy conversation. I think
[126] I was anticipating some future time when the needs of retarded citizens would be met in community settings and there would no longer be a need for Pennhurst and State centers such as this. As best I recall, it was in that context.
Q. So consistent with your previous testimony today, given the development of adequate community alternatives, that statement would be an accurate reflection of your comments to Loretta Schwartz?
A. Well, to say I don't think there should be a Pennhurst is not really accurate because that doesn't imply it and of itself, you know, the alternative.

See, it is one thing to say there shouldn't be a Pennhurst and then look for other alternatives, if they even exist, in contrast to saying perhaps someday there will not be a need for Pennhurst. Today there is a need for Pennhurst.
Q. So a correct interpretation of that statement would be, given the development of adequate services in the community for residents of Pennhurst, there need not be a Pennhurst, is that correct?

A. That is close. That is not my recollection of the conversation with her. It was in relation to future projections and needs of persons being met in the community. It wasn't what you would call Pennhurst specifically, but it was Pennhurst representa-
[127] tive of larger facilities such as this and then ceasing to exist because the need for them has ceased to exist. It was in that context.

Q. What about the part of the quotation, "Any large residential facility, good care is almost an impossible task"?

A. I don't recall saying that.

Q. Do you agree with it or disagree with it?

A. I don't think it is an almost impossible task. Relatively, the larger any agency, the difficult it is in terms of management, simply because of the span between top management and the direct receivers of care.

Q. In your experience and in your readings and your discussions with your colleagues, do you know of any institution the size of Pennhurst which is held up in professional circles to be giving good residential care?

A. Not personally. Dr. Clements, I think he referred to his facility as meeting that criteria or one at least in that general geographical area.

Q. He has a facility of 1,200.

A. He made reference to a facility of comparable size. I am not sure if it was phrased quite that way or if it was phrased in State compliance with JCAH standards. It may have been in that context. But the implication is that these needs were being met, at
[128] least to a greater extent than at other similar facilities.

Q. You don't recall exactly the facility that he was referring to?

A. No, but it was a facility of comparable size because I asked him.

Q. It wouldn't have been a facility of about 400 or 500 people, would it?
A. No. It was at least 1,200.
Q. In which state?
A. It was either North or South Carolina. If he gave me the name — I don't know that he gave me the name. I didn't know personally of that facility myself.
Q. So the answer to my question is—
A. I personally do not.
Q. You personally do not know of a facility?
A. No, I personally do not.
Q. In which good residential care is being provided?
A. No, "good residential care" as defined how?
Q. As defined by professionally acceptable standards, not in terms of JCAH standards or Medical Assistance standards, but in terms of common knowledge to the profession.
A. I don't know of any from personal experience, good in that context.
Q. Would you read again from the Philadelphia
[129] Magazine, Page 225, the following three paragraphs ending with, "I myself would go elsewhere and help."
A. "I came to Pennhurst filled with the hope that I could improve the lot of these people." That is a Schwartz term, "lot."
Q. We can talk about it after.
A. "I came to Pennhurst filled with the hope that I could improve the lot of these people. In Oregon, while I was working on my doctorate, one of our projects was to train the severely and profoundly retarded to work in industry, and there was a very low error rate among those we taught to do complex assembly work. Some actually earned more money than the doctors who trained them.

"When I first arrived at Pennhurst, the residents were being forced to move into the recently completed New Horizons Building. When I saw these wards, my flesh just crawled. I was ill when I left the building."

Do you want me to continue, or do you want to start to discuss it first?

Q. Continue.

A. "Many, theoretically all, of these people should be living in the community. If this place were closed down and people had a better place to go, I'd be de-

[130] lighted. I myself would go elsewhere and help.

" 'In fact,' Youngberg added with a slight tremor in his voice, 'sometimes I ask myself why am I here?' "

Q. Apart from the characterization of whether or not you had a tremor in your voice, did the paragraphs you read reflect substantially an accurate version of your discussion with Loretta Schwartz?

A. It was not an accurate reporting of my comments.

Q. Is it inaccurate in regard to the summarization of your work in Oregon?

A. It is not accurate.

Q. In what respect is it not accurate?

A. The first part where she said I came to Pennhurst filled with the hope I could improve the lot of the people. To my recollection, I was recalling the circumstances under which I came to Pennhurst, and that was through my past association with Wes White, who was the then Superintendent of Pennhurst. It was Wes White who introduced me to Special Education at the Rainier School in the State of Washington. I thought with his leadership and I could learn from him and share with him my experiences at Oregon, Wisconsin and Rainier subsequent to his leaving, and that together we would be able to do something at Pennhurst.

[131] With respect to my recollection of training severely and profoundly to work in industry in Oregon, this was true, with low error rate. That was significant. There were two, to my recollection, that earned more money than the doctoral students — not doctors, but doctoral students who trained them.

Continuing on, when I first arrived at Pennhurst, the residents were being forced to move into their recently completed New Horizons Building, which was the hyperactive patient building at that time.

"When I saw those words, my flesh just crawled. I was ill when I left the building." I don't recall that terminology at all, although I do remember Wes White, the then Superintendent, taking me through the building, which was not yet completed, and he and I expressed similar concern that they were still constructing facilities such as this with large living areas of the hospital type design.

There may have been further uncomplimentary remarks at that time, but I don't recall saying that my flesh crawled and that I was ill. I was probably upset, you know, that they were still building such buildings.

Going on, "Many, theoretically all, of these people should be living in the community." The state-
[132] ment by itself is accurate, but it was really just part of the whole conversation.

Q. That is essentially the same statement we read previously?

A. Putting it back in context.

"If this place were closed down and people had a better place to go, I would be delighted." I can't recall my phrasing anything of that nature. But again, it was in relation to someday perhaps all people, their needs will be met in the community and there would be no further need for Pennhurst.

Q. Would you be delighted if that happened?
A. I anticipate the day favorably that the need for Pennhurst will no longer exist. There is a need today. I hope today that in the future there will no longer be a need.

"Sometimes I ask myself why am I here." I know why I am here.

Q. Did you speak to Loretta Schwartz about that article after it was published?
A. No.
Q. Did you ever complain to her that you were misquoted.?
A. No, I did not.
Q. Did you ever complain to anybody in Philadelphia Magazine that you were misquoted?
[133] A. No, I did not, because I — well, okay, I did not.

MR. LASKI: I have no further questions.

* * *

MR. LASKI: Yes, I have a few questions.

[22-77] BY MR. LASKI:

Q. Mr. Foster, in your deposition you went through basically all the programs that you supervised and evaluated some of the program services at Pennhurst.

Is it a fair conclusion that at the deposition you stated that Pennhurst was not a normalizing environment?

A. That's right.

Q. Is your testimony today consistent with that deposition, that given available services in the community no one need be at Pennhurst?

A. That's right also.

Q. And your testimony is that there are a lot of practical problems in making that become a reality?

A. That's right.

Q. Is 't your practice and responsibility or is it Mr. Matthews' responsibility to review restraint and seclusion and accident reports?

A. Mr. Metzger?

Q. And you do not ordinarily review those in the course of the year?

A. No, I do not.

Q. And you reviewed especially the reports which

[22-78] you commented on in direct.

Did you review these especially at the request of your attorney?

A. I was asked if I knew anything about those particular instances, those particular cases, which i did.

Q. They had come to your attention previously?
A. Yes, they had.
Q. You just testified that — I forget the exact year, but the Pennhurst staff undertook a great deal of effort on a deinstitutionalization and institutional reform plan?
A. That's right.
Q. Again, what was the period of that plan?
A. That was approximately 1974, the end of 1974 — the beginning of 1975.
Q. And you testified that the institutional reform component related basically to the unit system and you did not comment on the deinstitutionalization, but I believe you said that fell short.

What were the components of that plan? What was the intent of that plan and what happened to that part of the plan?
A. The intent of the plan was to have a set of meetings on an ongoing basis between members of the institution, members of the five-county ARC's, and attempt to get the county administrators and BSU people involved, and just a whole host of community agencies in the Southeast Region to get together to deal with, first of all, some overall questions with respect to the problems with deinstitutionalization and also to attempt to initiate some programs or some proposals, at any rate, at which certain things could be done, even given the restriction of funding, the dual funding stream and all of those things.

[22-79]

That was the intent. In addition, —
Q. Excuse me.

Was the rationale behind that if you were going to get deinstitutionalization you would have to have the people in the community, the people in the BSUs, and the people in the counties as well as Pennhurst working?

A. That's correct.
Q. In other words, you could accomplish pretty much the institutional reform aspect as an internal staff operation, but to accomplish the deinstitutionalization you would have to bring together and coordinate the various agencies?
A. Yes.
Q. And what was the result of those plans?
A. There was a lot of meetings. Unfortunately, there was nothing as substantial as was done with the internal business on the lattices and exit and entry criteria.

We did — we were able to formalize some very small things in terms of attempts that had been going underway to get something started, and I am
[22-80] thinking in particular of a program in Pottstown which was run by the Montgomery County Association for Retarded Citizens, the backslider, and it was through this forum or this body that some of the plans, at least, were developed toward accomplishing that.

In addition to those regional meetings, I believe that it was every month — there may have been a few months which were missed, but there was a State — what they called a State Deinstitutionalization Reform Committee which later changed its name to The Mental Retardation Forum, which met in Harrisburg or Camp Hill, again to discuss some things — issues on a state-wide basis.
Q. Were people from the State Office of Mental Retardation in those meetings?
A. On occasions there was representation by someone from the Office of Mental Retardation, yes.
Q. Do you know if the Deputy Secretary of Welfare or the Secretary of Welfare knew about the progress or non-progress of the deinstitutionalization plan?
A. She was given reports on this, yes.

Q. Was there any response from the Secretary of Welfare or from any of his establishment as to how to correct the lack of progress that was being made on the deinstitutionalization phase?
A. Not to my knowledge.

* * *

[23-5] **Testimony of P. G. Samuels**

* * *

BY MR. WATKINS:

Q. Where do you currently reside, Miss Samuels?

A. Philadelphia.

Q. Are you currently employed?

A. Yes, I am, by the Commonwealth of Pennsylvania.

Q. In what capacity?

A. Director of Institutional and Program Support for the Southeastern Regional Office.

Q. What does the Southeastern Region encompass?

A. The five counties — Philadelphia, Chester, Bucks, Montgomery, and Delaware.

Q. How long have you held that position?

A. Five years with the Southeast Region; one year prior to that out of Harrisburg.

Q. Would you describe what your responsibilities are in that capacity?

A. Yes. I monitor the three institutions,twenty-one private licensed facilities, various support services, and have responsibility for coordinating the Act 256 or DGS projects.

MR. WATKINS: Excuse me one moment, your Honor.

BY MR. WATKINS:

Q. What does that DGS stand for?

[23-6] A. The Department of General Services. It previously was the General State Authority.

Q. In that capacity have you had occasion to become familiar with what has been referred to in this courtroom as Act 256 and the implementation or lack of implementation of Act 256?

A. Yes, I have, since January of 1973.

Q. And would you briefly tell the Court what Act 256 is and what its history has been in the department?
A. Yes. It is an act of the Legislature which previously was Senate Bill 1304, Printer's Number 1914, which was enacted. It was a capital budget bill.

A part thereof was for the Department of Public Welfare, Section 21. Section 21 covered the $21 million in question for the purpose of planning, design, and construction of mental-retardation service units, including the acquisition of property and construction or renovation of said property.
Q. Now were there any time limits in this act?
A. In reading it —
Q. Why don't you read the section of the Act that deals with the $21 million that you referred to?
A. All right. I am reading from Senate Bill 1304, Printer's Number 1914, starting on page twenty-nine, Section 21.

> For planning, design, and construction mental-retardation service units and acquisition of property, total population surveys, and
> [23-7] total system analysis as required to provide a definitive treatment and normalizing accommodations for mentally-retarded residents of Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties, and to be located in the same counties. The units are to provide accommodations for approximately 900 patients to reduce the population at Pennhurst State School and Hospital to a maximum of 1,000, this capital investment to provide logical dispersal and reorientation into the community for Pennhurst residents and alternatives to institutionalization for the Pennhurst waiting-list population and other mentally-retarded citizens of the

area who require such treatment and accommodations. This program is to be completed as expeditiously as possible so that the first units may be occupied not later than two years from the effective date of this act. (Base construction costs, acquisition, survey, and analysis, $16,863,000).

On the right-hand side appears $21,079,000.

Q. What is the difference?

A. The difference is roughly twenty-three percent of the construction cost, base construction cost, which is to cover the DGS.

Q. The Department of General Services?

A. Department of General Services administrative costs, including the architect's fees.

[23-8] Q. Is it that the projects themselves are to be developed and constructed by the Department of General Services?

A. Yes, they are.

Q. Let me back up a little bit now.

You came on board when? In what year?

A. I took on this project in January of 1973.

Q. Have you had occasion to become familiar with what occurred prior to January of 1973 with respect to Act 256?

A. In terms of the documents that were supplied to me by Harrisburg and other documents that I might have read at, say, other Commonwealth offices.

Q. As far as you can determine, what was done to implement this act between November 1970 and the time you came on board with the department?

A. The bill was signed on November 27th of 1970. In March of 1973, Scope, which is an official document — the number on the document appears as GSA 362-8-63—

It is a legal document, Scope, which is supplied to the General State Authority outlining the expenditure of any of these funds.

Q. Who submitted it to the department?
A. The Department of Welfare submitted it to the General State authority.
Q. When was that done?
A. It was approved by the General State Authority
[23-9] in March of 1971, is the date that I have.

MR. GILHOOL: Your Honor, I rise exactly to that point. The year of her testimony was 1973, her earlier testimony.

THE WITNESS: I am sorry, '71. A Scope was submitted at that point in the amount of $68,000 to conduct the planning phase, Phase I, it was referred to as.

That is oftentimes referred to as the McDowell report.
Q. All right.

What happened in Phase I?
A. There was an orientation meeting in April of '71, a preliminary meeting at the end of April of '71. The orientation meeting was the beginning of April and then a pre-funding meeting in July of '71 and a final meeting in the end of September of '71.

That report was then accepted.
Q. Let me ask you, you described these as preliminary meetings and pre-final meting and so forth.

Are these terms that commonly are used?
A. Yes. They are terms within the legal contract with the Department of General Services with a provider, a contractee.
Q. Are these required meetings?
A. Yes, they are. They are established at the orientation meetings, the time plan.
[23-10] Q. Did the McDowell report ever come to be?
A. Yes, it did.
Q. Do you know when?
A. It was approved in November of 1971, pending some minor changes which the Department re-

quested be made at the September 30, '71 final meeting.

Q. Have you had occasion to examine the McDowell report?

A. Yes, I have.

Q. And could you describe to the Court what it is?

A. It is a philosophical statement and then a population survey of the residents in the community, I believe also on the waiting list and at Pennhurst.

It then lists the number of programs, community-living arrangements, and day programs and support services that were seen as being needed to service the roughly 600-plus Pennhurst residents which were identified.

Q. Now you said that there was a population survey.

What did you mean by that?

A. I am not familiar with exactly what they did, but from reading the report it appears that they did analyze all of the residents at Pennhurst and came up with somewhere slightly in excess of 900 residents that could be dispersed or served through the sixteen - seventeen million dollars.

Q. Do you know how that analysis was conducted?

A. No, I do not.

[23-11] Q. What types of information did it contain, the population survey?

A. All that is in the report states that X number of residents in Bucks County, as an example, would need a Type 1 group home or a Type 3 group home, et cetera.

* * *

[23-52] [CROSS-EXAMINATION OF P. G. SAMUELS]

[BY MR. GILHOOL:]

Q. You testified as to what your recollection was of the Phase I McDowell report which provides a

blueprint for the planning and expenditure of Act 256.

Am I correct that your recollection was that Dr. McDowell and his staff did not collect data on the Pennhurst residents in terms of determining what types of residential programs they would need?

A. No. I said he did collect data. He must have in order to have made the recommendation that Bucks County needs X number of this type of facility.

I believe what I said was I did not know exactly how he went about collecting data.

Q. From your reading of the report you don't remember whether he explains his data collection?

A. I don't remember that. I haven't read the report.

Q. Have you read the report recently?

A. No, I have not.

Q. Do you recall whether the Pennhurst staff actually participated in the data collection about the residents there?

A. I would assume that they did, yes.

Q. Do you recall a chart or a figure in the McDowell report which indicated the characteristics that were tabulated by Pennhurst staff in terms of developmental level, current status, motor skills, eating skills, dressing skills, ambulation and toilet training?

23-53] A. No, I do not.

Q. You also testified, I believe, that your recollection of the McDowell report was that it planned for residences and programs to serve 900 plus?

A. I believe that was the figure, yes, 954-something.

Q. 959?

A. It could have been, yes. I don't know the exact figure.

THE COURT: I didn't quite hear your question.

What is the question that 950-some would be the answer to?

MR. LASKI: The witness testified on direct that her recollection of the McDowell report was that it had planned for 959 residents of Pennhurst; that it had planned programs and services and residences for those people.

And my next question is —

BY MR. LASKI:

Q. Do you recollect whether Dr. McDowell and his staff also planned for residences and programs for the 2,199 residents who were at that time on the waiting list for residential placement at Pennhurst?

A. I do not know specifically, but I would assume that they did since in the wording it includes the individuals in the waiting list.

Q. You don't recall a Table 7 in the McDowell report which was entitled "RETARDED ON THE WAITING LIST WHO NEED A SMALL LIVING
[23-54] UNIT IN THE COMMUNITY", which breaks down by county and living arrangements those people on the waiting list?

A. No, I do not.

Q. Do you recall from your reading of the report whether, in addition to the people on the waiting list and the 959 designated in Act 256, Dr. McDowell and his staff actually submitted plans for the other residents of Pennhurst who need small living arrangements in the community and in —

A. No, I do not.

Q. Dr. McDowell's report then — do you know whether Dr. McDowell's report had contemplated replacements in the planning of residential facilities for approximately 4,800 people as opposed to just 959?

A. No, I do not.

Q. Do you recall in what detail Dr. McDowell planned for the types of community-based residential facilities that were needed and the details by which he sited them in each county?
A. There were charts, as I recollect, that said X number — in each type of home or facility and the number of individuals for each.

And then it was totaled, therefore, we need X number of this type.
Q. And did the types include life support, infant nursery, child development, pre-vocational, habit-training, behavior, and habilitation-training type and crisis-assistance type?
23-55] A. Yes, if these are the nine types of group homes, yes.
Q. And each one of these types was designed and sited by county and by number of residents that would need that type of facility?
A. I believe each of those nine types were listed on the chart.

I do not remember if each county needed so much of each type.
Q. Did not the McDowell report county by county indicate the proposed facilities that were necessary for each county?
A. Yes. As I said, I think there was a chart for each county.
Q. Did you think the McDowell report provided a blueprint for placement in the community of those 959 residents designated in Act 256, the other residents of Pennhurst, and the people on the waiting list?
A. Yes, it did when it was accepted.
Q. You indicated in your direct testimony that one of the first things that happened in terms of implementation of Act 256 was that two years after the passage of that act group homes were removed from the project plan; is that correct?

A. No. One of the first things was the McDowell report was commissioned.

Q. One of the first things in terms of implementation of the McDowell report was that group homes were scrapped from the plan; is that correct?

A. That is the first thing that I found in going
[23-56] through some back records.

Q. And you testified that from going to back records you learned that Commissioner Goldman made that decision?

A. Yes.

BY THE COURT:

Q. Would you explain to the Court what you mean by the interpretation of his decision that group homes were excluded?

A. The nine types of CLAs, the community-living arrangements; but eight of the types, with the exception of the Type 1 or life-support units, were removed so that we were not going to spend any of the $17 million to acquire and renovate or construct small residential living units with the exception of the Type 1 because there was another funding for us available to provide those homes.

Q. I recall you did so testify, but you didn't tell us, what is that other funding?

A. It is the CLA. I don't know what it appears as in the county budget, but it is the community-living arrangements or the group-home program.

Q. Financed by the State Government or the Federal Government?

A. The State Government, I believe.

BY MR. LASKI:

Q. Do you know by what authority Commissioner Goldman made that decision?

A. I believe because this was a program for MR
[23-57] service units and he was the head of the MR programs in Philadelphia at that point. Therefore, he

said this is how we wish to spend the money that was appropriated to us.

Q. In other words, the Department of Public Welfare is making the decision in terms of how to spend the Act 256 money?

A. Yes, because it is my understanding that the money was part of the Welfare Department appropriation for the purpose of providing MR service units.

Q. The other funding source that you told the Judge about, was that designated specifically for 900 or 959 residents at Pennhurst?

A. Do you mean the CLA funding?

Q. Yes.

A. I don't know whom it was designated for originally.

Q. Was it designated for any residents of Pennhurst, specifically, as Act 256 is designated for residents at Pennhurst?

A. I don't know.

Q. Your testimony was after that decision the McDowell report essentially became inoperative and the planning process had to start again?

A. Yes. There are aspects of the McDowell report that we were able to salvage and use, mainly, the rough cost estimates, space allocations.

There are certain pages in it, as I remember, that say X per foot, X dollars, that type of thing; the descriptions of the programs.

23-58] Q. But at that point the planning shifted from previous State planning by the commissioner to planning by counsel?

A. I believe that was also planning and work between the McDowell report and November of '72, when the group homes were removed; but there was work by the counties. The counties had begun to do some site selection, et cetera, for programs to

implement the McDowell report arrangements and all of that ceased when the group homes were removed in November and then it had to begin again.
Q. The planning then went to the county level and each county presented and submitted plans?
A. Yes, I would say that's true following the November of '72 decision.
Q. And in accordance with your testimony those plans were submitted to the regional office?
A. Yes.
Q. And by that time, April of '73, you were at the regional office to receive those plans?
A. Yes, I was.
Q. Were they all approved at the regional office?
A. Yes, and I believe they were only approved as submitted.
Q. And then you transmitted them to the people in Harrisburg?
A. Yes.
Q. And were they then all approved there?
A. Yes, I believe they were. There were changes on
[23-59] the part of counties at later dates, at which time they requested that their original plans be revised, and that was done.
Q. And was it Commissioner Goldman at that time who made the decision to approve the five county plans for getting the GSA program moving again?
A. I do not remember who was commissioner or deputy secretary at that time.
Q. Somewhere from the Department of Public Welfare?
A. Someone there, yes.
Q. And once those program decisions were made and plans set in place, it was sent to the General Services Administration to do the ministerial task they always do to get construction?
A. Once the Department of Public Welfare ap-

proved the Scope, prepared and approved the Scopes, they were sent to them the General State Authority.

Q. That would have been in April of 1973; right?

A. I am not sure when the first set of Scopes were submitted.

Q. The language of Act 256 itself says nothing about fifty percent here or fifty percent there or fifty percent Pennhurst or fifty percent community, does it?

A. No, it does not.

THE COURT: I read it.

BY MR. LASKI:

Q. Do you know when that policy originated? Was it at the same time you changed policy on the group
3-60] homes that you changed policy on the numbers?

A. I believe that I have been saying that and implying that to the counties as a guideline probably since at least 19 — at some point in '74, '75. It may have been before. I am not sure when.

Q. It is clear that it isn't a guideline in communications from you and Dr. Rice to the regional office. You made that clear to the county in the last couple of years.

My question is where did that originate. Did it originate in your office or was that discussed with the Secretary of Public Welfare and people in Harrisburg?

A. I believe it originated in our office. It was discussed with Harrisburg.

Q. Was it your testimony that in about September of 1974 you were engaged in site selection and actually considered the location of some of the projects?

A. I believe that's roughly when we completed it.

I do not know that at some point between — well, during the period between February of 1974 and November of '74 that the eleven sites which

had to be acquired were acquired, that all acquisition was completed by November of '74.

Q. Now during this period of 1973 - 1974 were you preparing regular reports to the Secretary of Public Welfare or the Commissioner of Mental Retardation on the progress of Act 256?

A. I was preparing reports for the Regional Com-
[23-61] missioner and I believe some of them were sent to Harrisburg then. To whom, I am not sure.

* * *

[23-63] BY MR. LASKI:

* * *

Q. I show you PARC Exhibit 60, which is a report entitled DGS 523 Report from Russell Rice to Aldo Colautti. It is actually from Russell Rice and Pamela Samuels to Vincent Pettinelli and it is the same exhibit that Mr. Gilhool handed the Judge previously.

Did you prepare this report?

A. Yes, I did.

Q. And you prepared it on July 28, 1976?

A. If that is the date of it, yes.

Q. What was the occasion for you preparing this report in 1976?

A. I believe we were requested by either the Secretary or Mr. Colautti to provide a status report as of that time.

* * *

[23-77] BY MR. LASKI:

Q. To move along, have any of the projected bid dates in your memo to Mr. Colautti been met?

A. I think, if I remember, that one — the Pleasant Manor one. It looks like we were estimating that that would be met.

23-78] The Lower Merion was not met in January, though it was bid in May of this year, so that was close, if close counts.

And that would be all. I think then it sounds like one is anticipated still to be met and one to approach being met.

Q. Did you have an overall projection for the entire completion of the DGS project when you wrote this to Mr. Colautti?

A. It does not appear there but I think I did.

Q. Would it have been April 1, 1979?

A. It might have been, yes.

Q. And the projected date you gave to Mr. Watkins on direct was by 1980?

A. Yes, January of 1980, I believe.

Q. So on July 26, 1976 you were projecting an April 1, 1979 date and in May of 1977 you are projecting a July 1980 date?

A. No. It was January 1980.

Q. A January 1980 date?

A. (There was no response.)

Q. So in the last nine months we are basically in the same place we were nine months ago, when you wrote this memorandum, in terms of the anticipated time we are going to have to wait for the completion of the DGS projects?

A. For the completion of the last one or all of them, yes.

Q. So there has been essentially no progress made?

23-79] A. I don't know, we have got three out to bid and we have got Philadelphia's design started and moving.

That's nine out of seventeen. That's better than fifty percent.

Q. Just one further question.

When you assumed your position or in consequence, did you have occasion to read the report by the Bolton Associates of the MRI program for the

Pennsylvania Association for the Mentally Retarded?

A. I don't believe I read is in depth, no.

Q. I'd just like to read one sentence to you and ask you if you agree. The Bolton Associates said of the mental-retardation system that it lacks accountability, responsibility is diffuse, authority is non-existent or confused. Delays and confusion surround the mandated dispersion of nine hundred Pennhurst State School residents is an example of tragic proportions.

Would you agree with that?

A. Would you read it again, please?

Q. Sure.

The system lacks accountability, the responsibility is diffuse, authority non-existent or confused. The delays and confusion surrounding the mandated dispersal of nine hundred Pennhurst State School and Hospital residents is an example of tragic proportions.

THE COURT: What is the date of that report?

[23-80] MR. LASKI: 1973, April 1, 1973.

THE WITNESS: I would say when it was written that that probably was true, yes.

BY MR. LASKI:

Q. Is it true today?

A. No.

Q. How many people, how many Pennhurst residents are now living in DGS-built facilities?

A. None, because none of the DGS-built facilities have been built.

Q. How many Pennhurst residents have been dispersed since 1956?

A. What is your definition of Pennhurst residents?

Q. As defined in Act 256?

A. Presently residing at Pennhurst and dispersed as of a given date?

Q. Pennhurst residents who were living at Pennhurst when Act 256 was enacted.
A. According to the programs that were operational as of April 2 25th, it appears that thirty-seven Pennhurst or ex-Pennhurst residents were being served in our Embreeville residence with a projection that by June 30th there would be thirty-nine Pennhurst residents plus four Embreeville residents, with a possibility of an additional two from Pennhurst.
Q. That's next June? That's going to come up by June?
A. By June 30th, the thirty-nine plus four.

Testimony of R. G. Rice, Jr.

* * *

[26-34] BY MR. GILHOOL:

Q. Mr. Rice, does any resident at Pennhurst have to receive services there because of his handicap?

A. Would you explain further?

Q. Does the handicap of any of the 1200-some residents of Pennhurst require that services be delivered to him in that restrictive, that segregated a setting?

A. No.

Q. Everyone at Pennhurst, therefore, could, so far as his or her handicap is concerned, receive services

[26-35] in a less restrictive, more integrated community setting?

A. If there was an appropriate residential arrangement in the community, appropriate day-program services, and support services and ongoing relationship with the responsible county, that is correct.

Q. And the absence of those services is the only thing that keeps anyone at Pennhurst at present?

A. Obviously, that has to be the guide.

Q. Of course, all of the things that are necessary for the presence of the residents?

A. That's correct.

Q. You testified yesterday it would be inhumane, I think, to disperse the residents of Pennhurst tomorrow.

Would it be inhumane to disperse them a year from now?

A. What numbers are you describing?

Q. There are presently 1200 residents at Pennhurst.

A. To disperse the total number of people within a one-year period?

Q. That is correct.

A. That would be inappropriate. As I described, the act, the Mental Health-Mental Retardation Act, is basically a county-based system. The counties are responsible for after-care services as I described and the counties have identified a number which I have
26-36] described that translates into 370 individuals as their maximum capacity to properly serve those individuals.

Q. Okay.

So that the inhumane part that you made reference to is not a matter of timing and effect, but a matter of the production of the community services that are necessary to sustain the residents in the community?

A. That's correct.

MR. GILHOOL: May I approach the witness, your Honor?

THE COURT: You may.

BY MR. GILHOOL:

Q. I show you PARC Exhibit 63, which is "Community Living Arrangement Program Analysis and Program Plan for Fiscal Year 1977-78," and, in particular, an unmarked page thereof towards the back of the document.

Do you recognize that document?

A. Yes.

Q. All right.

Now the page to which I direct your attention has a title called "Definitions of Community Living Arrangement Types;" is that correct?

A. Correct.

Q. And it defines there eight types of community-living arrangements?

A. Correct.

26-37] Q. And the first type is the developmental maximation unit; is that correct?

A. Correct.

Q. And that type is meant to serve what sort of handicapped persons?
A. Defined as an educational residential program for the medically complex, multiply-handicapped persons.
Q. Do you know how many such people requiring developmental maximation units presently reside at Pennhurst?
A. I don't know off the top of my head but I can have access to it.
Q. Please take the time and use the access.
A. Approximately fifty-nine.
Q. Fifty-nine?

* * *

[26-45] [BY MR. GILHOOL:]
Q. Now you testified about half an hour ago that this was — do I have your language correct? — the first acceptable plan for deinstitutionalization at Pennhurst put together by the State, the region, and the county?
A. I believe so.

MR. GILHOOL: I am uncertain, your Honor and counsel, whether a copy of this plan has been presented to the Court.

MR. WATKINS: No, it hasn't and I will be glad to do so now.

Your Honor, we have specifically discussed this occurrence when we were drawing up the pre-trial order. In my pre-trial order I don't show this as listed.

MR. GILHOOL: I have no objection.

MR. WATKINS: Does anybody object?

MR. PEABODY: No.

MR. WATKINS: We shall provide counsel with copies.

(Commonwealth Defendants' Exhibit CD-727 was marked for identification.)

BY MR. GILHOOL:

Q. Now putting aside for the moment Mr. Cotton's
[26-46] demurrer and Montgomery County's demurrer, you testified, did you not, that this plan is your plan and the counties'?

A. A joint planning effort.

Q. A joint planning effort, whose product has—

Now wait a minute. It was planned jointly, but this product has the assent of your office and of the counties?

A. I have documents from the counties confirming that, yes.

Q. All right.

Is this plan also the plan of Deputy Secretary Hobbs?

A. Correct.

Q. And is it the plan of the Deputy Secretary of Mental Retardation Services Malone?

A. Correct.

Q. And the plan of Deputy Secretary Aldo Colautti?

A. Correct.

Q. And of Secretary Beal?

A. Correct.

Q. And of Duane Youngberg?

A. Correct.

Q. And is the plan, in other words, of the State Department of Public Welfare?

A. Correct.

Q. And of the counties?

[26-47] A. Correct.

Q. It represents, does it, the best judgment of what you can do in the next year and a month?

A. That we can do?

Q. Yes.

A. Yes.

Q. And it represents your best judgment of what you can do in that time, formulated after seven weeks of trial, after two years of litigating; is that correct?

A. It is the plan for '77-'78 for the dispersal of the individuals at Pennhurst Center as described, regardless of where they are in point of time.

Q. It is the judgment of the Department and of the counties of what can be done in the next year and one month, or longer, as you indicated, when the money was available?

A. When the money comes into the present funding stream in the present system that we are working under; that is correct.

Q. Okay.

Now let's look at the particulars of the plan, if we may.

Do you have a copy in front of you?

A. Yes.

Q. At page one the first item there, among the 169, is a special CLA funding, sixteen out of the sixty-eight already dispersed?

A. Right.

[26-48] Q. And fifty-two to be dispersed?

A. Right.

Q. Is that the unspent community arrangements money from fiscal '75-'76?

A. Mr. Bilyew described at one time the funding process as related to that sixty-eight individuals. That is only part of the total CLA dollars.

Q. Well, these dollars represent a part of the unspent funds in fiscal year '75-'76; is that not correct?

A. These were additional dollars given to the Southeast Region above its original appropriation for CLA.

Q. I appreciate that but my question, however, is where do these dollars originate?

Do they originate as unspent dollars in the fiscal year '75-'76?
A. Unspent '75-'76?
Q. Yes. Sometimes you call them carryover dollars, don't you?
A. These are —
Q. Are you aware that during fiscal '75-'76 the five counties in the Southeastern Region failed to spend certain dollars for community-living arrangements and for other community services?
A. These funds came from, at that time, family resource services.
Q. That is to say—
[26-49] A. It was carryover money from the FRS program, when it was in Appropriation 57.
Q. All right.

Family resource services appropriations for the fiscal year '75-'76, which were allocated to the counties but not spent by them, were carried over and in December of 1976 transmuted into the fund for the CLAs; is that correct?
A. Right. It was in the same appropriation at that time.
Q. Okay.
A. None of these moneys, by the way, came from the unspent funds in the Southeast Region.
Q. They came from unspent funds elsewhere in the State?
A. That's correct.
A. Aha, aha.

Now this money was put out last December; is that correct?
A. I believe so, yes.
Q. And it was put out for community-living arrangements for occupancy within sixty to ninety days; is that correct?
A. Yes.

Q. And in your deposition of March 14th, at page 160, you testified that within this fiscal year, meaning the current fiscal year, those sixty-eight residents at Pennhurst will be dispersed into community-living arrangements; is that correct?
A. That's correct.
[26-50] Q. Now we have got one month to go in the fiscal year.

Will the sixty-eight be living in the community and receiving services there by June 30th?
A. I cannot guarantee it, but it will be shortly afterwards.

Obviously, the identification of the defined areas, the outside date is December 31st.
Q. The outside date for the sixteen —
A. Totally.
Q. 1 through 5 is December 31st?
A. Obviously, some of the dispersal will take place prior to that.
Q. All right.

And what is your expectation with respect to the sixty-eight? When is that going to take place?

On March 14th it was by June 30th. On this date what is it?
A. I don't have the complete count in front of me.
Q. Item Number 2 is contracted foster care.
A. Correct.
Q. And that calls for ten residents at Pennhurst to move into foster care in the community?
A. Correct.
Q. On March 14th you testified, did you not, at page 171 of your deposition, that before the end of the fiscal year ten to fifteen then Pennhurst resi-
[26-51] dents would be in foster care; is that correct?
A. If that's what it says.
Q. Now will ten to fifteen residents at Pennhurst be in foster care by June 30th?

MR. STUTMAN: Page 171.

THE WITNESS: The answer to the question is that those individuals will be in foster-care placements prior to December 31st.

MR. GILHOOL: All right.

BY MR. GILHOOL:

Q. They will not be by June 30th?

A. I cannot guarantee that they will be there by June 30th, but they will be before December 31st.

Q. Okay. All right.

A. Now on March 14th you thought that it might be as many as fifteen who would be in foster care by the end of this fiscal year.

Why does it say ten here rather than fifteen?

A. The ten is a conservative number. There is the possibility, the likelihood, that it could be in excess of ten.

Q. So that these are conservative numbers?

A. That is a conservative number.

Q. I thought you testified about forty-five minutes ago that these numbers are bounded at the outside by your judgment of the capacity of the mental-re-

[26-52] tardation system, State and county, to actually deliver?

A. That's correct.

Q. But it is not correct for this foster-care number?

A. We identified two areas, one which is current funding and one which was new.

The combination of those equals 370 individuals.

Q. How many of the 201 are you intending for foster care, have you planned for foster care?

Have you identified both the appropriate program and made the judgment that those resources can be created in the period of time indicated?

A. I believe the counties have identified four individuals.

Q. Yes. Okay.

Now with respect to the ones on Line 3, that is, community-living arrangements vacancies, you showed twenty people filling those vacancies.

Do you expect that by the end of June or again are we somewhere in the period between now and December 31st?

A. As identified, no later than December 31st.

Q. All right.

Now you were in the courtroom when Mr. Bilyew testified?

A. Yes.

Q. Did you hear him testify or did I hear correctly that as of the middle of April or was it at the end of
[26-53] April there were seventeen true vacancies in the community-living arrangements program for Southeastern Pennsylvania?

A. No, I did not hear that.

Q. Do you have a recollection of what number of true vacancies he spoke of?

A. I believe the true vacancies, if I can recollect, was ten, I believe. It wasn't that number?

Q. It was less than seventeen; all right.

Now did you also hear Mr. Bilyew testify that for those true vacancies as of the end of April there were already referrals and I understood him to mean multiple referrals for all of them?

A. Right.

Q. Now he didn't testify that any of those referrals were from Pennhurst, did he?

A. I don't recall having heard his testimony.

Q. He did, however, testify that apart from the true vacancies of ten or seventeen there were theoretical vacancies, that is, there were 120 CLA slots which had been authorized and funded some time ago, about two years ago, which programs have not yet become operational; is that correct?

A. The point is that in his discussion with the county these twenty individuals could be served in the CLA vacancies.

Q. My question at the moment is not about those twenty individuals, but rather do you recall that Mr.

26-54] Bilyew testified that there were 120 CLA slots authorized and funded for some few years in the five-county area that had not yet opened?

A. No, I don't recall that.

Q. You don't recall.

Of your own knowledge are there approximately 125 CLA slots funded and authorized over the last few years but not yet opened?

A. No, not — that's not true.

Q. How many are there?

A. I don't know, but I know it is not of that magnitude.

Q. What magnitude is it?

A. I don't have those details. There is an individual on my staff who would have those details. I do not have those details.

Q. Well, suppose it is of the order of magnitude of twenty or fifty or a hundred, you say it is not 120.

Is it more than 120?

A. It would be less than 120 and based upon his assessment twenty additional individuals could be served.

Q. You are back to the CLA vacancies?

A. Yes.

Q. Twenty could be served in additional vacancies?

A. Correct.

Q. With a current true vacancy of ten or seventeen and with some undefined number.

Do you know when you asked him the question

26-55] how many people can you put into CLA vacancies?

A. I asked him to look into the present status and how many he projected in conjunction with the counties.

Q. And the report to you is the sole basis for the presentation here of that number of twenty?
A. With stipulation with the counties, yes, that is a distinct possibility.
Q. Okay.

Did you ask him, when he said twenty for vacancies, whether he meant twenty vacancies or whether he meant authorized funded but not opened programs that might open in the next year and a month?
A. That would?
Q. That might.

Did you ask him that would?
A. That would, as I understood it in the beginning.
Q. All right.

And that applies only in this CLA vacancies of twenty?
A. True, true.
Q. Okay.

Now 4 and 5 — seventy-two transfers to Embreeville and fifteen transfers to Woodhaven Center or to other centers.
A. That's right.

[26-57] BY MR. GILHOOL:
Q. Let's try the statewide basis for a moment.

I recall you testified a little while ago that you got funds unspent in other parts of the state for these sixty-eight.
A. That was a different appropriation.
Q. I understand. You said that was a family resource service appropriation.

Have you, since March 14th of this year, received a statement of the unspent state allocation funds in the five-county Metropolitan Philadelphia area?
A. Have I received it for '75-'76?
[26-58] Q. '75-'76, the fiscal year that ended last June.

A. The last county submitted that on January 27th.
Q. On January 27th?
A. Yes, but I don't have access — I don't have that particular figure.

That's when the report was submitted.
Q. So that you did have those figures by March 14th?
A. I did not personally have those figures, no. I do not know when that goes —
Q. When did they become available to you?
A. I don't have them as of yet.
Q. Then I can't ask you and you can't answer what order of magnitude these are.

Those figures were not taken into account in the formulation then of this plan for the next year and a month; is that correct?
A. When those counties have identified, once they give each year's expenditure report confirmed, and based upon the appropriation that the Legislature appropriates, there are X amount of dollars to go to the counties.

That would be a combination of new dollars as well as dollars that were carryovers from the previous year.
Q. Of course. I understand that as a general matter.

My question is whether the carryover funds from the last fiscal year were taken into account in
[26-59] the preparation of this plan.

You have told me that as of this date you don't know what those funds are.

How is it fair to say that for —

Are you the author of this plan? Are you the idea man who put a lot of thought into this?
A. There were many individuals involved.
Q. All right.

Now were those funds taken into account in the formulation of this plan for the next year and a month or more?

A. The reflective process has assimilated, so I will say yes.
Q. And how many dollars were they that were taken into account?
A. As I said before, I don't have that specific figure.
Q. You then took them into account. If your answer if yes, it was taken into account here, please tell me who put them into the account.
A. Not specifically for the particular plan.
Q. Aha! Then it was not —
A. These moneys were coming from the State.
Q. I beg your pardon?
A. These moneys have been placed in the county programs throughout the state. I cannot earmark at this point in time what that particular thing means in terms of each county's program.
[26-60] Q. Did any of the five counties get any of those funds?
A. I don't know if they have or they have not.
Q. How did they distribute those funds if you didn't know how much was left over, if you couldn't tell the State how much to distribute?
A. That would be up to the regional secretaries and —
Q. I see. Those —
A. I don't see those figures.
Q. Those figures don't go to the Commissioner of Mental Retardation in the five-county area whose duties you testified were responsibility to present a plan to the five counties to make those figures go? Those figures don't go to the Commissioner; is that what your testimony is?
A. That's correct.

[26-61] * * *

BY MR. GILHOOL:
Q. Mr. Rice. Exhibit 56 shows 342 people transferred between the date January 1, 1972 and May

31, 1976 from Pennhurst State School and Hospital to Embreeville State School and Hospital.

Is that correct?

A. Correct, correct.

Q. Now your proposal is, in the next year and one month, to transfer an additional seventy-two from Pennhurst to Embreeville; is that correct?

A. That's correct.

Q. And with those seventy-two more Pennhurst residents Embreeville will then be an institution of 414; is that correct?

A. (There was no response.)

Q. Now that's mentally-retarded residents; is that correct?

A. No, I don't believe it will be over four hundred, no. I believe it is closer to 385 but I don't have the specific figures in front of me.

Q. You don't have the specific figures in front of you?

A. No.

Q. Is there anything there you might find the figures in?

26-62] A. I believe the present Embreeville Mental-Retardation Census is somewhere between 300 and 313 individuals.

Q. So that the site of Embreeville then will be somewhere between 372 and 385?

A. That's correct.

Q. All right.

Do you know how many mentally-ill residents there are at Embreeville State School and Hospital?

A. Today? No, I don't.

Q. Do you know the order of magnitude?

A. (There was no response.)

Q. Is it 300? Is it 200? Is it 400?

A. I don't have that figure in mind.

Q. Do you have any idea of what ball park it is in?

A. Prior to the transfer to Norristown —

Q. Oh, there were transfers from Embreeville of mentally-ill patients to Norristown?
A. Excuse me, to Haverford.
Q. To Haverford?
A. Correct.
Q. And indeed it is the case that those transfers —
A. Those transfers have taken place. I don't know what the present mental health —
Q. Over the last several years; is that right, transfer of mentally-ill patients from Embreeville to Haver-
[26-63] ford State Hospital have taken place over the course of the last three or four years, have they not?
A. Well, this has happened fairly recently when they phased out the mental-health unit at Embreeville.
Q. And that took place because both Embreeville and Haverford were under-utilized; is that correct?
A. That's correct.
Q. And because the mentally-ill patients or persons who have been moved from Embreeville to Haverford, mentally-retarded patients have been moved from Pennhurst to Embreeville; is that correct?
A. Yes.
Q. Now you testified earlier that none of the 1200 residents at Pennhurst required, because of their handicap, services in an institution of the size and segregation of Pennhurst.

Do any of the 414 require, because of their handicap, an institution of the size and segregation of Embreeville?
A. They don't require it.

* * *

[26-78] [BY MR. GILHOOL:]
Q. Now this move of seventy-two Pennhurst residents to Embreeville had been contemplated for quite a long time; is that correct?

A. That's right.
Q. When was it first considered?
A. Back in the late 1960s, I believe.
Q. I am sorry, I don't mean that reference of 342 who have already gone.
[26-79] I am talking about the additional seventy-two whom you propose be moved from Pennhurst to Ebreeville in the next year and one month.

When was the move of this seventy-two first proposed?
A. My recollection is that it was part of the original thinking back in the late 1960s, when the transfers began.
Q. You understand that the transfers to Embreeville generally were part of the original thinking in the late sixties?
A. Surely.
Q. Or early seventies?
A. Yes.
Q. But my specific question is when did consideration of transferring another seventy-two from Pennhurst to Embreeville originate?
A. In my recollection it was not an additional seventy-two. My recollection is that it was part of a larger figure that was identified, I would imagine, by DPW.
Q. Back at the beginning?
A. Back at the beginning.
Q. I see.

Do you know what that larger figure was?
A. No, I don't.
Q. Do you know what that larger figure would be, that is, the mere fact that this is the last seventy-two
[26-80] that the region, state, and counties in their original plan are going to recommend be transferred to Embreeville?
A. If the moneys are appropriated as I defined and we get down to the figure of 850 for Pennhurst.

Q. And then they will be gone, the 200, through July of 1983, if all of that happens?
A. I said as far as getting down to that 850 figure, then there would be no need to tranfer additional individuals to Embreeville.
Q. Now there have been nine transfers to Embreeville since you have been Commissioner of Mental Retardation; is that correct?
A. I believe that's correct.
Q. Why haven't the seventy-two, since the thought long ago was to transfer this additional seventy-two, including this seventy-two — how come these seventy-two are being proposed for transfer next year instead of over the last few years?

Why hasn't it happened before?
A. Because the building that they would be residing in — one particular building — is not presently certified under the Medical Assistance program.

It is projected that it will be certified, meeting Medical Assistance care standards.
A. So this proposal of moving seventy-two to Embreeville in the next year and a month depends
[20-81] upon the certification of another building to meet Medicaid standards, which has not yet been certified?
A. No, but they are —
Q. When do you expect it to be certified?
A. The moves, the transfers from Pennhurst will take place prior to December 31st. That has been the first phase of the life safety code renovation.
Q. So that your projection on this compliance with the life safety code as distinguished, for example, from Pennhurst's compliance about which you testified at some length in direct, your projection is that that certification is going to be in hand before December 31st?
A. Correct, and that —

Q. And that thereupon you will move the seventy-two people?
A. Correct.
Q. Is that the only reason why these seventy-two people have not been moved to Embreeville heretofore?
A. Prior to their moving they will have to be moved into a certified building with appropriate numbers of staff to meet the minimal Medical Assistance standards.
Q. Do you know how much money is being spent to refurbish this building to meet the life safety code and then the higher standards of Title 19?
A. For that particular building? No.
I have a figure for the total life safety code.

26-82] Q. At Embreeville?
A. Yes.
Q. Okay.
What is that figure?
A. $1,800,000, I believe.
Q. $1,800,000?
A. That's correct.
Q. For Embreeville, as compared with $1,800,000 for Pennhurst?
A. Correct.

26-84] * * *

Q. Okay.
Now I should like to show to you PARC Exhibit Number 25, which is a series of letters dated in the spring of 1972, this one from Edward R. Goldman to the Commissioner of Mental Retardation, the then Commissioner of Mental Retardation of the Commonwealth of Pennsylvania, to William D. Beach, Jr., the Secretary for Mental Health and Mental Retardation, entitled "Proposed Expenditure of All Capital Funds for Pennhurst," and I should like to

read to you or have you read, as you prefer, a particular paragraph and ask you whether —

A. Why don't you read?

Q. Okay.

Commissioner Goldman describes the Embreeville transfer operation as, of course, a compromise.

It would be foolish to consider this stopgap phasing of Pennhurst residents into two-year-old hospital buildings designed to provide custodial care for mental patients as anything but a temporary measure forced upon us by the emergency of an obsolete, deteriorated, and overcrowded state school and hospital system. To do so would violate Office of Mental Retardation principles and policies to the
[26-85] same degree that Pennsylvania's existing mental-retardation institutions violate these principles and policies. However, it is a compromise that could be acceptable and one the Department might implement without losing credibility if it is made clearly subject to the constraints implicit in the Office of Mental Retardation principles and policies and with a guaranteed time limit placed on the continuing use of Embreeville consonant with a rigorous departmental enforcement of county program responsibilities to develop and establish adequate and appropriate residential and non-residential community alternatives to institutionalization for mentally-retarded persons and their families.

Does that say satisfactorily to you what you would say about the Embreeville transfers?

A. I don't quite understand your question. It says —

THE COURT: Whatever it says, it says beautifully.

THE WITNESS: Now what was the question?

BY MR. GILHOOL:

Q. Under your proposal are the transfers of the seventy-two to Embreeville to be time-limited?

A. It is seen as a transitional facility, not any facility of permanency, a facility of compromise.
Q. Okay.
A. It is seen as a transitional facility.
Q. Has the transition happened for the 342 who
[26-86] were transferred from Pennhurst to Embreeville between 1972 and 1974?
A. There have been some transfers out of Embreeville but not to the degree that was stated in that paragraph that you read.
Q. You testified a half an hour ago that there have been fewer moves from Embreeville to community-living arrangements?
A. Right.
Q. Than from Pennhurst to community-living arrangements, and that's under thirty or, as you said the 180 figure, of forty or forty-five.
A. There have been less at Embreeville; correct.
Q. Now among the 342 people who went to Embreeville some time ago, are the 200 for whom you propose community-living arrangements in the next year and a month or more?
A. I don't think so, no, but I don't know the individual names.

26-102] * * *

BY MR. GILHOOL:
Q. I show you POPULATION RESIDING AT PENNHURST, a report of the Pennhurst State School and Hospital dated October 31, 1976, and direct your attention in particular to that part of the chart which designates county of residence, and then a total number of residents, a total of persons who originate in that county, and it says division by 121.

So that in your plan for the community residential services for forty-seven people in Bucks County,

that compares, is it correct, with fifty-three Pennhurst residents originating in Bucks County?
A. As of that date?
Q. As of October 31, 1976.
A. Correct.
Q. And in Chester your plan for nineteen compares with sixty-four Pennhurst residents originating in Chester County; is that correct?
A. Correct.
Q. And as to Delaware County, your plan of twenty-seven compares with 132 Pennhurst residents originating in Delaware County?
[26-103] A. Right.
Q. And as to Montgomery County, your sixty compares with 124 Pennhurst residents originating in Montgomery County?
A. Correct.
Q. And as to Philadelphia, your forty-eight compares with 491 originating in Philadelphia County?
A. Correct.
Q. And that's without reassigning the 400 Pennhurst residents who, an average of twenty-five years ago, originated in other counties or even out of the State; is that right?
A. That's just the Southeast Region.
Q. Exactly.

That chart, however, shows an additional 400 residents completing the population of Pennhurst as of that date who originated elsewhere; is that correct?
A. Correct.

* * *

[27-3] PROCEEDINGS

(Resumed in Courtroom 10B at 2:17 o'clock P.M.)

* * *

CROSS EXAMINATION (resumed)

BY MR. GILHOOL:

Q. Mr. Rice, let us return to our discussion of what you called the first acceptable plan for the
[27-4] deinstitutionalization of Pennhurst, which as you testified yesterday, represents the best judgment of the State, the region, and county governments of what can be done in the next year and one month.

I have placed on the stand in front of you five exhibits, 33 through 37, which were before you when we closed yesterday.

Those are, are they not, the letters of response from the five county administrators to your request or direction to them in February of this year that they submit a needs assessment and budget projections on deinstitutionalization for their respective counties?

You had an opportunity yesterday afternoon to look those exhibits over, did you not?

A. No, I did not.

Q. No, you didn't?

A. No, I didn't.

Q. Will you take that up now then?

What I want first to review with you are the number of community-living placements that each county in response to your direction presented to you with budget projections.

Can we take the county by months?

A. Sure.

Q. Montgomery County, and that's Exhibit 33, responded with plans and budget projections for community residences and services for 130 Pennhurst residents, did they not?

[27-5] A. This document was not in response to the request that the region had made. In Montgomery County the February 28th document simply identifies the needs assessment and budget projection for

all people residing at Pennhurst. It does not pertain to what their capabilities are for '77-'78.

There was a subsequent document —

Q. Go ahead.

A. — which describes that in response to the original request and that is a March 8th letter.

Q. Do you have that document with you?

A. No, I don't, which identified some of the people that would be served, the types of residential-support services, day-program services, and the source of this money that could be additionals.

In addition to this particular documents, Montgomery also sent in a similar document for individuals they had placed in institutions outside, out of Pennhurst.

Q. The second document you speak of is dated March 8th, did you say?

A. That's correct.

Q. And the letter you have in front of you, which is Exhibit 33, is dated February 28th?

A. That's correct.

Q. Now how did Mr. Manning chance to send to you a letter dated February 28th which lays out plans for community services and their costs for 130

—

[27-6] A. Okay. This was something that Montgomery County had done on their own and not in response to the Southeastern Region.

Q. What is the date of the request by your office by you to the counties, that they submit to you their needs assessment and budget projection on deinstitutionalization of Pennhurst?

A. As I said yesterday, the request began at a meeting at Deputy Secretary Hobbs' office on January 12th.

There was a follow-up meeting that I had with the county administrator on the 27th of January.

My assistants made phone calls, one of which was to Montgomery County, on January 28th and as a follow-up to that, then on February 4th we sent out a memorandum in follow-up to that telephone.
Q. That was the date of the memorandum sent to the five counties?
A. Yes, but this particular project that's in front of us was being compiled long before.
Q. All right, all right. You can come back to it if you wish. —
A. This is not their response to the region's request.
Q. Though it came after those conversations with the county and after the February 4th memorandum asking for a needs assessment and cost projection?
A. But this was — this particular project was in the works prior to those statements.
Q. What was prior?
A. This exhibit that you give me. Following this exhibit, it is coincidental. The dates are coincidental.
[27-7]
Q. Wait a minute.
It is dated February 29th?
A. That's right.
Q. PARC 33, a letter from Mr. Manning to you?
A. Right.
Q. And you say it was in the works long before January, the first part of January?
A. This is not in response to the regional request.
Q. I heard you say that, but more recently you said that that letter was in the works long before early January of 1977.
A. Based on my communication with Montgomery County, I have a particular date that they were doing their part of what they identified as their ongoing responsibility, and that it would be done not only for Pennhurst Center but for other individuals who were residing in institutions throughout the State.

Q. Who was it from Montgomery County who told you that the county was doing that?
A. Well, this is in my contact with Mr. Manning, who is the —
Q. Mr. Manning?
A. Yes.
Q. And when was it that he told you that Montgomery County was preparing a plan and cost projection for people who had originated in Montgomery County, who presently were living in Pennhurst and other institutions?

[27-8] A. I do not have a specific date. I just know that that was occurring.
Q. Did you know last fall? Did you know last summer, or did you know a year before that?
A. I don't have a particular date, but I know that it was being done prior to the request, the specific request for '77 —
Q. Prior to January of this year; and was Montgomery County doing this on their own initiative?
A. That's correct.
Q. Your office had not asked Montgomery County or any other county to do any such thing?
A. No. That's part of their responsibility.
Q. What do you mean, that's part of their responsibility?
A. The base service units, through the county, are mandated by the act to assess, to plan, to direct and coordinate the delivery of services for those individuals in Montgomery County.
Q. Has any other county ever presented to you a plan and a set of cost projections for residences and community services for the total population by origin from that county in Pennhurst State School and Hospital?
A. Not in that detail, no.
Q. Not in that detail?

When did they present to you such plans, albeit not in that detail?

A. Who?

[27-9] Q. The other counties.

A. I don't have specific dates, but there have been requests for funding in order to serve a specific population of people.

Q. That wasn't my question.

The question was have any of the other counties at any time presented to you a plan and cost projection like that Montgomery County plan for all of the residents at Pennhurst who originated in that county?

A. No.

Q. No?

Montgomery County undertook this not on request of the regional office nor on the regional office's direction, but on their own?

A. That's their responsibility.

Q. That's their responsibility.

You are saying that they have the responsibility to do that?

A. That's correct.

Q. When are the counties supposed to do that?

A. That's an ongoing responsibility.

Q. Ongoing?

Are they supposed to discharge that responsibility yearly?

A. No.

Q. When are they supposed to discharge it?

27-10] A. They don't discharge that responsibility.

Q. That, I think I appreciate very well; but you said it was the responsibility of all counties to prepare that kind of a plan?

A. No, it is not.

Q. What is it their responsibility to do then?

A. Their responsibility is to assess the individuals

who are mentally retarded in that county, to develop plans for them, —

Q. I see.

A. — to have an ongoing relationship with them regardless of where those individuals are placed; and they are to coordinate the delivery of services that impact upon the individual regardless of where the placement is.

Q. I see.

And the counties are responsible for doing that for each person who may have originated in the county who is at Pennhurst or any other institution?

A. Correct.

Q. And they are responsible then for having or maintaining a plan like Montgomery County's Exhibit 33?

A. Not necessarily in that format.

Q. Not necessarily?

A. Montgomery County chose to do it in that form.

Q. What form have other counties chosen to do it in?

A. What form?

[27-11] Q. Yes.

A. Some of them have requests for specific funds for different types of programs.

Q. I am sorry, we may be repeating —

A. I think we are.

Q. — but I want to be very sure that I understand what you are saying.

Has any other county ever presented to you a plan for residential and other community services along with cost projections for all of their residents at Pennhurst?

A. And I stated no to that originally.

* * *

27-32] [BY MR. GILHOOL:]

If the Pennhurst budget was deployed into the five-county area for CLAs and supporting services, would that, in your judgment expand the capacity of the mental-retardation system in the Southeast Region to produce CLAs and supporting services?

A. Obviously, that would.

Q. Have you or has your office ever determined how many providers of community-living arrangements there are in the five-county area?

A. The number of providers? I don't know that, the number.

Q. Would twelve seem to be about the right number, eleven non-profit institutions and one profit institution?

A. Mr. Bilyew would have that information. I don't have that.

Q. Do you have an idea of how much — is that the right magnitude? Are there about twelve providers or do you think —

A. No, there's many more than that.

Q. I am not talking about the number of group homes. I am talking about Ken-Crest, for example, that runs —

A. I don't know the number.

Q. You don't know the number?

A. No, I don't. I wouldn't want to guess.

Q. Whatever the number, have you or has your office ever called all of the present providers of those 500 CLAs developed over the last four years together to say something like we must and we want to expand the system as far as we can: please come back to me in, say, two weeks and give me your best

27-33] judgment of how many community-living arrangements you could have on the street, so to speak, that you could produce for me in the next year?

Have you done that or has your office?

A. No. The contract between the CLA and the county is with the county commissioners.
Q. I see.

It is the county commissioners' responsibility to do that?
A. The contract is between the county commissioners and the particular provider; and the county commissioners' arm is the MH-MR administrator and his particular program.
Q. Has the county, to your knowledge, ever called all of the providers together and said tell me how much you can do?
A. I don't know if they have or not. That would be more appropriate to ask the counties.

* * *

[27-37] Q. All right.

Now let me take you back to that Montgomery
[27-38] County letter that you received, that you testified was not in response to a request of yours.

However it orginated, that letter made out a plan, did it not, and costed that plan out for community services for 130 Pennhurst residents; right?
A. That's right. They didn't talk how many people could be dispersed and in what time frame.
Q. Of course, I don't want to go into that.
A. It was a needs assessment and budget projection.
Q. I don't intend to go to the time either, so you are really talking about something else.

That letter costed CLAs and community services on an annualised basis for those 130 Pennhurst residents, delivered to residents in the community at $1,900,000 annually?
A. I don't know. If that's what the figure is.

Q. You have the letter in front of you.
A. What exhibit?
Q. Our Exhibit 33, and that submission also said that the cost at then current costs of maintaining those 130 people at Pennhurst would be $2.8 million, almost $2.9 million on an annual basis; isn't that correct?
A. That's what is hand-written down at the bottom here.
Q. So that —
A. I don't know if that's the true figure, by the way.
Q. What is your opinion about that?

[27-39] Montgomery County has said that for 130 it costs nearly $3 million at Pennhurst for a year and for 130 in the community it would cost nearly $2.8 million.

Is that consistent with your notion of what it would cost?
A. I would say that to maintain an individual at Pennhurst and be able to serve an individual in the community, that it would be less expensive. I don't know how much less, but it would be less expensive.

I think that's basically what this indicates.
Q. Do you find order-of-magnitude difference — almost three million as compared with almost two million?
A. I don't know how to compare them. It seems that it would be almost a million less.
Q. So if the entire Pennhurst budget of — did you say $31 million in your testimony?
A. I don't know. I'd have to pull that figure.

MR. WATKINS: $32,302,000.

MR. GILHOOL: Okay.

BY MR. GILHOOL:
Q. If that entire budget were deployed to provide services in the community, then your testimony is

that it would more than cover the cost of community-living arrangements and other services necessary and proper in the community for all of the residents of Pennhurst?

[27-40] A. And if you took into account, assuming that took into account deploying official funds as well, and realizing that somewhere between seventy-five and eighty percent of those are in staff, and that the majority of the remainder are operational costs to maintain the buildings, obviously, there would be some difficulties in deploying the money, which means deploying the staff, as you well know, the unions involved.

If you are putting all of that aside and saying that there are no problems inherent in displacing 1562 staff and you are talking about a pure dollar figure of $31 million, that would support that population in the community.

Q. So that your answer is yes, there would be money left over after deploying the budget from providing community services for all of the people transferred out?

A. If the staff could be deployed appropriately and there would be the day services and the support services available through that, yes.

Q. Now is the plan complete? Have you prepared any plan for the deployment of Pennhurst staff to the community or their retraining?

A. No.

Q. When you say you haven't do you mean to say the regional office hasn't prepared such a plan?

A. That's correct.

Q. And Pennhurst has not?

[27-41] A. That's correct.

Q. And the State department has not?

A. The State department?

Q. Has not?

A. DPW?

Q. Yes.
A. Correct.
Q. And I take it the counties have not?
A. I would say that's correct.
Q. Have you ever read the McDowell report?
A. When I first came.
Q. When you first came?

Do you recall that that report in 1971 said that a necessary condition of actually achieving community services sufficient to displace or to replace Pennhurst would be the careful preparation and execution of a plan for placing Pennhurst staff in jobs in the community?
A. That would have to be critical since most of the money is staff.
Q. Right.

And the report said the very same thing in 1973, did it not?
A. Correct.
Q. Are you a student of documents like that, the Governor's Management Review?
27-42] A. I have not read that.
Q. You have not?

Would you be surprised — would you expect, indeed, that the Governor's Management Review undertook a careful review of mental-retardation services, institutional and community? Would you expect that such a review would have listed very high among its recommendations a definition in precise and concise terms of a plan and of procedures to transfer State institutional employees to community programs?
A. Is the question would I be surprised?
Q. Would you expect a review of that depth and intensity to come to that recommendation?
A. As a necessary part.
Q. But to your knowledge there exists now and has not existed since 1971 any such plan?

A. Well, I think it is important to note that Secretary Beal has requested a budgetary freeze 1975-76 to 1977-78, that, there will be single-stream funding.

I think there has been ample testimony about some of the difficulties with the numbers of appropriations that affect the institutions and the counties and, obviously, if there was single-stream funding some of the problems would be eliminated.

However, the request of Secretary Beal for the past three years has not come to fruition.

[27-50] * * *

[BY MR. GILHOOL:]

Q. Let's turn now, Mr. Rice, to the other aspect of the plan which you submitted yesterday, and that
[27-51] was headed "Institutional Internal Reform."

The two parts, are they Mr. Rice,

A. The two parts what?

Q. The two parts, the community facilities to reduce the size of the population at Pennhurst for fifty, and several million dollars for improvements at Pennhurst are really quite closely related, are they not?

A. Correct.

Q. And really this is a plan for an institution of 850 to secure federal Medical Assistance funds, isn't it?

A. That is part of the plan. The other part is the dispersal.

Q. It just so happens that —

Well, where did the 850 come from? Why 850?

A. As I described earlier, there were meetings at Pennhurst in April, I believe, —

Q. Why 850? Why not 1,000? Why not 500?

A. The care standards, the Medical Assistance, ICFMR regulations identify, as you see here on page two, certain things that must occur and, as you

see, much of that impact is on the living area, the bedroom area.

Q. All right.

A. Taking those care standards into consideration, an architect from DPW sat down with the program people from Pennhurst, the regional and the central office; and with those care standards in mind and with blueprints for every building, every area at
[27-52] Pennhurst, sat down and superimposed the care standards regulation on top of those blueprints and the life safety code regulations.

As you see, one of these is that a bedroom will accommodate not more than four persons.

Q. Yes.

A. Now, as I described earlier, some of those bedrooms are for three, two, one, based upon the program and the needs of the individuals.

That process identified, after every building was done in that fashion, in getting the pieces of furniture in there and the like, an 850 figure as the maximum population under the Medicaid standards.

Q. 850 is the figure at which you could qualify the total institution at Pennhurst for Medicare?

A. That's correct.

Q. How have you asked a preliminary opinion or any advice of HEW, the Title 19 administrators, about whether 850 will qualify all of the institution for Medicaid?

A. The information we have is that that will be — that figure will be an appropriate figure.

It says a maximum of four and I described some have three, some have two, some have one.

Q. Incidentally, you have been advised, to your satisfaction at least, that you will qualify at 850?

A. Based upon the process we went through.

27-53] Q. All right.

At the time of your deposition on March 14th of this year, at page 137, you said that the size of

Pennhurst would be 1,004, and that that size would qualify Pennhurst for federal Medicaid funds.
A. That was our — we had done some preliminary work prior to having the services of the DPW architect.
Q. Yes?
A. And taking into consideration that an individual could be placed in a particular residential area below the maximum of four, and utilizing at Pennhurst and the region and the central office what the more appropriate total would be, we come down to a figure of 850.
Q. Okay.

Now, as long ago as September 1st, and I am reading from the minutes of the MH-MR, which are Exhibit 44 — at that time too, according to these minutes, you reported that a population of 1,000 would qualify Pennhurst for Medicaid.
A. That was basically the thinking. I think that was a different statement.
Q. So the move was made from 1,004 to 850 because on rethinking 850 is what was necessary to qualify for federal Medical Assistance funds; is that correct?
A. As I said, there has been additional effort put forth, additional individuals involved, an architect
[27-54] involved; and again utilizing the care standards as defined we came up with a figure of 850 individuals.
Q. All right.

And that will go for Medicaid?
A. Yes.
Q. Now you testified at the very beginning to presenting a plan that is being developed with extensive consultations with Pennhurst staff and the other actors whom you identified, and that includes presumably Superintendent Youngberg?
A. Very critically in the interim reform.

Q. Now were you in the courtroom late last week when Superintendent Youngberg testified?
A. I was not here.
Q. Do you have a report of his testimony?
A. I have had brief summaries, yes.
Q. Did anyone tell you that Superintendent Youngberg testified —

MR. GOLDBERG: Objection, but go ahead.

BY MR. GILHOOL:

Q. — testified last week that the size of Pennhurst was to be 1,004 and further testified that he had not heard or participated in any discussion of a size of 850?

THE COURT: Do you have an objection?

MR. GOLDBERG: Your Honor, that's asking for a hearsay statement as to whether someone else told the witness something.

[27-55] THE COURT: You may rephrase the question by saying are you aware that the superintendent testified in this courtroom.

BY MR. GILHOOL:

Q. Are you? Are you so aware?
A. I am aware that he did testify?
Q. Are you aware that he testified that 1,004 was to be the size of Pennhurst?
A. Last week?
Q. Yes.
A. No, I am not aware because he was involved in this time period in April 20 - 22, involved in a sponsor —
Q. Is there any explanation why the superintendent would have testified last week 1,004 and would further testify that —

Let this stand for itself, he did so testify.

MR. GOLDBERG: Where? Have you the page in the record where he testified?

MR. GILHOOL: No. I don't have daily copy.

MR. GOLDBERG: Then I must object to the question because I don't see where you can show that that was the testimony.

The witness has already stated he doesn't know what Dr. Youngberg testified to.

MR. WATKINS: I don't know what the relevance of it is.

MR. GILHOOL: The relevance of it, your
[27-56] Honor, if I have to state the obvious, is that Mr. Rice said this plan was prepared after extensive and careful consultations and as recently as last week one of the prime consulters testified that he had never heard of the 850 and the institution, by his expectation, was to be at 1,004.

[27-61] * * *

[BY MR. GILHOOL:]

Q. Now apart from the physical requirements of Title 19, receiving federal funds under Title 19, does Title 19 require individual habilitation plans for each resident of a qualified institution?

A. Yes.

Q. Yes, sir.

A. Yes, sir.

Q. Do you intend to provide individual habilitation
[27-62] plans for each of the 850 who will reside at Pennhurst?

A. We intend to provide what is necessary to meet the minimal ICFMR regulations.

Q. So you do intend to provide individual habilitation plans?

A. Correct.

Q. Will these individual habilitation plans be provided by the base service units or will they be provided by Pennhurst staff?

A. In conjunction with.

Q. Pardon me?

A. In conjunction with.
Q. I don't understand.

Do you mean both Pennhurst staff and base service unit staff will assess and draw the individual habilitation plans and otherwise do all of those things necessary?
A. Correct.
Q. All right.

Now what additional staff will this require in the base service units?
A. I think you should ask an administrator.

* * *

27-65] * * *

[BY MR. GILHOOL:]
Q. Mr. Rice, I am not asking you about the people in the community. I am asking you about the 850 people whom you intend to keep at Pennhurst.

You have agreed that there must be individual habilitation plans for each of them. You further said that it is your intention to provide them. You have further said that the individual habilitation plan assesses all of the work that must be done and that will be done jointly by the base service unit and Pennhurst.

My question now is how much additional staff
27-66] is it going to require to do that?
A. I don't know how many additional staff it will require.
Q. Do you know how much additional staff it will require at Pennhurst?
A. For the population of 850 people?
Q. No, no, for individual habilitation plans.
A. Let's assume a new figure—
Q. Is it your understanding that fewer than ten percent of the residents at Pennhurst currently have an individual habilitation plan?

A. Fewer than ten percent?
Q. Yes.
A. That is not my understanding.
Q. What is your understanding?
A. That it is greater than ten percent.
Q. What is your understanding with respect to the base service unit's participation in the formulation of habilitation plans for Pennhurst residents?

Is it your understanding that fewer than ten percent of the residents have had base service unit participation in the formulation of a plan for them?
A. I don't know the figures.
Q. Does ten percent seem about right?
A. I don't know what the figure is.
Q. You testified that it had been the base service
[27-67] unit's responsibility and, indeed, it has been under regulations since 1968, has it not?
A. Correct.
Q. Do you know whether that responsibility has been discharged to the 1200 people at Pennhurst?
A. Totally? I don't know if that has been discharged totally for a hundred individuals.

I think that questions about county possibilities should be directed to the county administrators.
Q. Do you have the responsibility under the act to enforce the regulations of the State department with respect to the counties?
A. That's correct.
Q. And one of those regulations says the base service unit shall prepare life management plans, individual habilitation plans for residents originating there who are at institutions such as Pennhurst.
A. Correct.
Q. And that has been correct and approved since 1968, hasn't it?
A. Yes.
Q. Do you know whether the counties are in compliance with that regulation or not?

A. I don't know if they are totally in compliance, no.
Q. Would you expect that fewer than ten percent of the Pennhurst residents have had base service unit participation in any planning for them at Pennhurst?
27-68] A. As I have testified, I do not know.
Q. All right.

Well then, I guess now I understand why you can't tell me what staff or what the cost of individual habilitation plans are.
A. I think you have to go to those individuals who have that specific information.
Q. Yes, sir, but —
A. And that would be the superintendent and the county administrators.

I can't have all of that specific information. It is obviously staff that work for me, and there are staff in the counties and the institution who have that individual data.
Q. Did you go to them for that information?
A. Did I what?
Q. Did you go to the people you have just mentioned for that information?
A. What information?
Q. The information you were just addressing.

You said I should go to the superintendent and the counties for that information.

My question to you is have you gone to them for that information?
A. I have not gone to them for that information.
Q. Okay.

27-70] * * *

[BY MR. GILHOOL:]
Q. Right. It was never asked specifically.

Mr. Rice, does Medicaid require five and a half hours of active programming for each person at Pennhurst?

A. No.
Q. You intend to provide five and a half hours of active program for everyone at Pennhurst?
A. We would intend to, yes.
Q. In this plan with this budget, this staff, this cost, —
A. I have reported a number of times this plan will meet minimal ICFMR regulations.

The information that we have regards a minimum number of two and a half hours of what the standards identify as dead time, without any services.

The intent is to go beyond that as far as possible with the additional staff and with reorganization we
[27-71] intend to go beyond the two and a half, 2.75 hours of individualized structured programming, and we do intend to reach a five — five and a half, whatever is appropriate for that particular individual.
Q. When do you intend to reach five and a half hours?
A. First we have to reach two and a half hours.
Q. All right.

I am not interested in your intentions as to the far future; I am interested in your intentions in this plan that you have prepared for this Court.

In this plan will you provide two and a half hours of programming a day? Will you provide five and a half?
A. Minimally we will provide 2.75 hours per day, with the instruction of the staff that will be increased to over three.

And again the intention, first we have to meet the minimal requirements and then we will have the increase, whatever is appropriate for that particular individual, recognizing that the five and a half might not be appropriate for every individual — maybe more, maybe less.
Q. The plan is a three or four-page plan. That plan

includes the provision of 2.75 hours of active programming daily for 850 residents at Pennhurst.

Is that your testimony?

A. Minimally.

Q. Minimally? All right.

A. And with the statement I have already said, that
27-72] in a relatively short period of time we can increase that with redeployment of staff.

Q. All right.

And what is your understanding of the current average hours per day of active programming for Pennhurst residents?

A. Presently?

Q. Yes.

A. One and a half hours up to two.

MR. GILHOOL: I think the record will bear me out. I think the record will show that the highest number of hours of average programming at Pennhurst in testimony by any witness for the defense —

MR. WATKINS: Your Honor, is he arguing with the witness? He got an answer.

I wish counsel would get on with his cross examination.

THE COURT: If you are going to ask a question, ask it please.

MR. GILHOOL: Your Honor, I am trying to lay the basis for the question.

BY MR. GILHOOL:

Q. If it is one and a half hours presently, what is the additional cost in staff in dollars to raise that progamming to the 2.75 hours?

7-73] A. It is shown in the report. With the reduction to 850 people and an increase of $159,950.

Q. I understand that, but what is the net addition to program staff to raise the average active programming from one and a half hours to two and a half hours?

What's the gross figure? Now many more people are going to be working on programs.

A. On program and rehabilitative services, that would be an increase of twenty-three people over the existing complement of today. As described, it is eleven additional staff plus redeployment of the existing complement.

Q. On October 4th of 1976 did you not address a letter to Mr. Vincent J. Fitzpatrick, and this is PARC Exhibit 32, I say this with counsel's permission to expedite.

Did you not write Mr. Fitzpatrick, the president of the Pennhurst Board of Trustees, in order to satisfy both DPW's goal of institutional reform in 1977 and the minimum intermediate care standards Pennhurst must utilize its staff to further the programs' velocity by providing at least five and a half hours a day of structured programming, five days per week, and better utilize staff to increase the quantity and quality of weekend activity?

A. And I think I covered that quite extensively in deposition. I was asked that specifically; and the intent is to reach the five and a half.

[27-74] First, we must meet minimal ICFMR regulations. It is covered quite extensively in the deposition.

Q. But in the letter you said in '77 to meet minimum care standards you must provide five and a half hours.

Now you are telling me that while you have a hope, you have planned and projected providing 2.75 hours before December of 1978 or before July 1st of 1978.

Now which is it?

A. The intent is to meet first the minimal ICFMR standards and beyond that to provide the necessary programming.

If that translated into five and a half, fine.

The intent has been first to meet the minimal standards. That was explained to the Board of Trustees at a meeting with Dr. Youngberg, who was present, and that was explained in my deposition.

Q. How many additional staff, and what would they cost, would you require at Pennhurst to meet five and a half hours?

A. It depends on the population of people.

Q. For 850?

A. For five and a half, I don't know what it would take to meet it.

Q. All right.

And meeting five and a half hours is not part of the plan presented to this Court for an institution of 850 planned through July of 1978; it that correct?

[27-75] A. That's correct. The plan is to meet the ICFMR standards.

Q. Now why the change? In the October 4th letter you said to me to meet the ICFMR standards we have got to have five and a half hours of active programming.

For it is the premise of your plan that you don't.

A. As I explained in deposition, the intent was always to provide the five and a half.

Obviously, we first have to meet minimal standards. That has not changed.

That was made clear to the Board of Trustees, certainly to the Board as well as the superintendent who was there as well.

Q. In October of 1976 you wrote to Mr. Fitzpatrick that ICH, Title 19 standards, require five and a half hours of programming and yet in this plan you are going to reach only 2.75.

A. The Board of Trustees —

MR. WATKINS: Excuse me.

Could counsel please show that portion of the deposition? We all know where it is, but possibly the witness would like to see it.

MR. GILHOOL: Or he is going to have to be asked the question a half a dozen times, I suppose.

The question will be asked if it is answered.

[27-76] THE COURT: May I ask a question?

BY THE COURT:

Q. Are you testifying now that you consider the minimum standard now to be only two and a half hours?

A. That's correct.

Q. Did you at that time, when you wrote that letter, consider the minimum standards were five and a half hours?

A. Following that letter it was clarified that it was two and a half hours.

Q. In other words, is it your testimony that that letter was not an exact statement of what the minimum standards are?

A. That's correct; and that's what I said here.

THE COURT: All right.

Let's proceed.

BY MR. GILHOOL:

Q. And it was after that that you discovered then that these plans were for 2.75 instead of a plan for five and a half hours?

A. To meet minimal Medical Assistance standards; correct.

Q. All right.

Now you did say the MA standards accept two and a half hours of program —

MR. WATKINS: Your Honor, that's the same question.

MR. GILHOOL: No, it is not.

The JCAH standards — this is a question about JCAH standards requiring more.

[27-77] THE WITNESS: That was also in the deposition.

THE COURT: Let's answer the question. If you know the answer let's hear it.

THE WITNESS: I don't know what figure; as I reported, I don't know if it is five and a half.

I believe my deposition says that it is closer to the five and a half than the two and a half.

MR. GILHOOL: All right.

THE WITNESS: It is not usually translatable even with the JCAH standard.

It is based upon the individual treatment plans and how they are carried out, which for some individuals might translate into only three or four hours of structured programming.

So it is not very easily translatable in JCAH.

BY MR. GILHOOL:

Q. Your understanding is that the JCAH standards do not require numerical hours of actual programming?

A. They do not translate into so many hours; that's my understanding.

Q. You were asked also on deposition do you know of any professionally-acceptable standards, any other than what we have talked about, which would accept two and a half hours for minimum hours of active programming for residents of an institution like Pennhurst; and your answer then was no.

Is that your answer now?

27-78] A. That's correct.

Q. With respect to your own professional standards, Mr. Rice, would you accept two and a half hours of active programming for 850 residents of Pennhurst or, indeed, any mentally-retarded person as providing an appropriate service and habilitation for such a person?

A. Me personally, professionally?

Q. Yes.

A. As I stated in the deposition, the two and a half hours is minimally acceptable.

Professionally, I have concerns about that particular figure, but to me —

Q. Two and a half hours is minimally acceptable in that it meets ICH, Title 19, but it is not your own professional opinion?

A. That would depend upon what was needed for that particular individual. Generally two and a half doesn't — for myself professionally, two and a half hours, myself professionally, no.

Q. Now would you, as a Commissioner of Mental Retardation of the Southeast Region, approve a proposal for a community-living arrangement program which represented that there would be available day-program services of no more than two and a half hours a day?

A. Speaking very generally, it would depend upon the individual, that particular living arrangement.

[21-79] It is very difficult to respond to that type of —

As I reported before, particularly as identified in JOAN, it depends upon what is available for that individual, recognizing that an individual could receive so many minutes of occupational and physical therapy and as part of the planned program he might have a rest period of an hour, let's say.

That, to us, would suffice as part of his planned program.

Q. Don't you, as a matter of practice, require, before you approve any CLAs are opened, appearances of day programs that extend at least five and a half hours a day?

A. (There was no response.)

Q. Why else have we heard so much —

MR. WATKINS: Your Honor, he is asking a second question.

He has to wait until the witness answers the first one.

MR. GILHOOL: I will be glad to wait.

BY THE COURT:

Q. Can you answer the first question?

A. The averages are difficult to respond to. What I would respond to is that it does require an appropriate day program for that individual.

BY MR. GILHOOL:

27-80] Q. Yes, and in an appropriate day program —

A. That does not always translate into five and a half hours.

Q. Of course, it doesn't, but for the overwhelming number, approaching the proverbial 99 and 44/100s percent of retarded people, an appropriate day program exceeds five and a half hours a day, does it not?

Workshop programs, for example, exceed five and a half hours a day, don't they?

A. Correct.

Q. Schools exceed at least five and a half hours a day; isn't that correct?

A. Correct.

Q. Day-activity centers, funded by Act 256 funds, maybe one or two of which are open, exceed five and a half hours a day, do they not?

A. Possibly they do.

Q. And you require as a condition of opening any residence in the community that such day programs be available, don't you?

A. Correct.

Q. All right.

But it is not a condition of residence at Pennhurst that five and a half hours of day programs should be available, is it?

A. First, we have to meet the minimal standards.

Q. I understand that.

7-99] * * *

BY THE COURT:

I ask you this question as a professional, somebody that's apparently been educated in the field of retardation.

If you were given the complete authority and had the funds available and were in charge of a program, how long would it take you to transfer the 1200 residents that are now at Pennhurst from Pennhurst into appropriate slots in the community?

And I might add by "appropriate" I mean the type that you have been testifying that you think are necessary.

A. How long?

Q. How long would it take you, if we give you complete authority and you have the funds available?

How long would it take you to get the job done,

[27-100] forgetting about conflict?

A. It is not a simple answer; I can't give you that simple answer.

Obviously, a lot would have to go into a planning effort in order to disperse our people properly.

I can't give you a simple answer. I don't think it is fair to identify a specific time frame.

Q. You can't do that?

A. I can't do that now, no.

That doesn't mean I can't. I just don't have enough information.

Q. I just want to point out to you, of course, all through your testimony you have been talking about receiving plans, making plans, evaluating plans; and I didn't think that it was going to be such an unfair question and I thought perhaps that you could give an answer to that.

A. Well, —

Q. Do you still say you can't?

A. Well, I think this should be clarified, that I think my testimony has been that it has been the intent of the Department of Public Welfare that the commu-

nities be the responsible agency for dispersing individuals in the community.

The whole thing revolves around decentralization. The whole concept about the individuals who are closest to those mentally-retarded people would
7-101] be most sensitive to their needs and if they were served in the community, by the community, those individuals would have the sensitivity and the knowledge of what they would need and they would be accessible, more easily accessible.

Q. I know. I think I have understood your testimony to be that as far as the 1200 residents that are now at Pennhurst, it would be more beneficial in the future for each of them if they received appropriate care and services in residences in the community.

A. I don't think there is any — there is no argument there.

Q. There is no argument, but — all right.

There is one thing you just can't do and that is try to force somebody to give an answer, but your answer is —

Why don't you think about it over the weekend? I am not trying to get you to do additional work, but maybe it is just one of those things that if you thought about it the answer would come to you, you know.

A. It is very complex. It is a complex issue.

THE COURT: Well, yes. I suppose it is. See you Monday.

[28-3] * * *

BY MR. GILHOOL:

Q. Mr. Rice, we were examining county plans when we parted on Thursday and the particular matter on hand was the Bucks County plan for the next fiscal year, which you had testified was re-

ceived in your office a week ago last Thursday or Friday. As of last Thursday you testified you had not had an opportunity to look it over.

Have you had an opportunity since last Thursday to look at the Bucks County plan for '77-'78?

A. No, I have not.

[28-4] * * *

[BY MR. GILHOOL:]

Q. You testified that under the MH-MR Act each county must formulate and submit an annual mental-health and mental-retardation plan and costs; is that correct?

[28-5]

A. Correct.

Q. And that plan is submitted for the review and approval of the Department of Public Welfare, is it not?

A. Correct.

Q. In addition, the counties must submit annual reports on expenditures to the Department again for departmental review; is that correct?

A. Correct.

Q. And Section 512 of the Mental Health-Mental Retardation Act of 1966 says, does it not, if at any time after the approval of a plan the Department determines after hearing that such county or combination of counties is not complying with regulations promulgated under this act and that as a result the needs of the mentally-disabled persons therein are not being adequately met, the Department shall provide mental-health and mental-retardation services for such county and counties.

Is that correct?

A. Correct.

Q. Now during your tenure as Commissioner of Mental Retardation for the Southeast Region, and that has been since the summer of 1975, has the

Department ever disapproved an annual mental-retardation plan submitted by anyone in Bucks County?

A. Not to my knowledge.

Q. Has the Department ever refused finding for
[28-6] any programs in any of the five counties based upon the inadequacy of the annual mental-retardation plan?

[28-7] Q. And you have not been informed that during the earlier period the Department ever took any such action?

A. That's correct.

[28-11] * * *

[BY MR. GILHOOL:]

Q. Now you testified, I believe it was Thursday, did you not, that the base service units had the responsibility to draw and provide life-arrangements plans for each of their residents, including persons who are resident at Pennhurst who originate in that base service unit, and that those life-management plans must include individual habilitation plans and exit plans in the case of Pennhurst residents?

A. Correct.

Q. That responsibility of the base service unit originates in the 1968 regulations, in Section 522.1 and 522.2, does it not?

A. (There is no response.)

MR. GILHOOL: For the record, those regulations are PARC Exhibit 66 and if the witness wishes I will provide a copy to the witness.

May I show this to the witness, sir?

THE COURT: All right.

BY MR. GILHOOL:

Q. I place before you, Mr. Rice, PARC Exhibit 66 and show you the regulations effective November 15, 1968 and call your attention to 522.1 and 522.2;

and that is the source, so far as the 1968 regulations
[28-12] are concerned, of that duty of the base service unit to provide life-management plans for residents at Pennhurst, is it not?

A. Correct.

Q. The duty of the base service unit also has its source, does it not, in the February 10, 1973 regulations of the Department, which are numbered 5200, Appendix 4?

A. Correct.

Q. Now, Mr. Rice, were you in the courtroom when the following testimony was given or have you otherwise become aware of the following testimony:

Felix Roy, the first witness, I believe, for the Commonwealth, an employee for five years at Pennhurst and an experienced actor, testified that in the provision of training at Pennhurst he had volunteered to play any role at all — psychologists, social workers, team leaders, ward aid — but he could not play a base service unit representative because he had never seen a base service unit representative.

Were you in the courtroom for that testimony or have you otherwise become aware of it?

A. I was not in the courtroom. I received summaries on a daily basis of what occurred when I was not present.

Q. Now respecting the testimony and the same question, if you will, of Catherine Clark, the Director of Social Services at Pennhurst, who testified that a base service unit of a county mental retarda-
[28-13] tion office had been contacted for each resident at Pennhurst and asked to participate in the formulation of a plan for him and that that had been the policy over the last several years at Pennhurst, but that various persons in the base service unit had responded to that request.

Were you in the courtroom for that testimony or have you been made aware of that testimony?
A. I was not in the courtroom and I have been generally aware of the responses.
Q. The third piece of testimony from Dr. Betty Hare, based on the review of 120 records, a sample of one out of ten at Pennhurst — she testified that a review of those records showed that eighty percent of the residents at Pennhurst — their records showed no response and no participation by base service units and that only ten percent of those records, twelve out of the 120, and the same figure applies to the universe in which only ten percent of those residents had base service units participating, did you hear that testimony or have you been made aware of it?
A. I did not hear that testimony directly and again I have been generally made aware of people's testimony on a day-by-day basis.
Q. All right.

Now if that testimony and that evidence is correct, then Section 512 of the Mental Health-Mental Retardation Act providing that if the counties do not
28-14] carry out their duties under the regulations, the State shall —

MR. WATKINS: Objection, your Honor.

It calls for a legal conclusion.

BY MR. GILHOOL:

Q. From you understanding of the Section 512 of the Mental Health-Mental Retardation Act requiring that the State shall provide mental-health — mental-retardation services when the county fails, would that section obtain.

MR. WATKINS: The same objection, your Honor.

THE COURT: I think it is all right to ask him if he did understand it as the head of the department.

Do you call it the department or the bureau?

The WITNESS: The Department of Public Welfare, the Southeast Region.

THE COURT: He can answer whether it is his understanding and he can say whether or not this was the situation.

The WITNESS: I am saying that that could be applicable.

However, one of the other sections that's identified, either 508 or 509, Addendum 5, says that a particular county, if they feel they are unable to provide the specific services defined in the act, would seek in the Department for relief of that responsibility.

None of the counties have done so in my tenure and I don't have knowledge that that has been done
[28-15] in the Southeast Region.

MR. GILHOOL: Okay.

BY MR. GILHOOL:

Q. Your understanding is that the act would allow a county to petition the department to provide services which the county could not provide?

A. It was a possibility on a year-to-year basis if it can be justified.

Q. And a second device for the State actually executing the responsibility is for the State itself to give notice and hold a hearing and following the hearing to displace the county and provide the services?

A. If the county says they are unable to provide that particular service.

Q. Well, had your office or more generally had the Department, with respect to the five counties, on the basis of the failure of the base service units to carry out their duty under the 1968 regulations, the 1973 Appendix 4 of the regulations, ever withheld approval of a county's plan?

A. No.

Q. Has it ever withheld dollars from the county on the basis of a violation of those regulations?
A. It has not.
Q. And I take it has never given notice of a 512 hearing preparatory to the State providing those services itself?
[28-16] A. They have not.
Q. You, personally, as Commissioner, don't get to the base service units or the programs in the community to, in effect, investigate or explore their operations, do you?
A. No, I don't.

As I testified before, the responsibility for directing, controlling, and monitoring the base service units was purely with the county.

In my dealing with the county officers, however, I do not have any direct control over county programs.
Q. Now you leave it to the county offices to, in effect, investigate, monitor, and police the performance of the base service units; is that correct?
A. That's their responsibility.
Q. I am not asking you if that's their responsibility. I am asking you if that's a fact.

You never go the county offices to, in fact, investigate, monitor, and police base service units in the discharge of their duties; am I correct?
A. Correct.

Deposition of R. Rice

[68] * * *

Q. I take it, then, from your testimony that you've never recommended a decrease in the expenditure of monies?
A. That's correct.
Q. You've recommended increases, the expansion of programs?
A. Yes.
Q. Okay.

Now, what kinds of programs have you recommended expansion for?
A. My specific — recommendations haven't generally been made on a county by county basis, but have been made on a regional basis in terms of additional dollars in the base allocation. It's my belief —
A. The 43 Appropriation?
A. Right.

It's my belief that the county should be receiving funds generally, additional funds, across the board.

[69]

Q. For all the services that it should be providing?
A. Generally speaking, it can be for all types of — the county program, the county mental retardation program, in my estimation, is not receiving generally enough funds in order to —
Q. Presently?
A. Presently.
Q. When you say that the county programs are not receiving enough money, what do you mean?
A. Appropriation 43 and Appropriation 57 should be expanded significantly.
Q. Why should those appropriations be expanded significantly, as you put it?
A. One, to meet one of the basic intents of the mental retardation programs in the state is to provide as

many community-based residential and support services in the county program.

Q. So one of their reasons would be to institute the basic intent of the 1966 Act, as you refer to it?

A. Yes.

Q. Is that correct?

A. Yes.

Q. What other reasons? There's a fairly general reason, to meet the basic intent.

[70] A. Well, the reason was to provide as many community-based residential and support services to keep individuals as close to their communities as possible in terms of receiving services, whether it's in the home or whether it's in a residential program.

Q. The funds currently are insufficient to fulfill that purpose?

A. In my estimation, yes.

Q. Do you have a notion as to the amount of increased appropriations required to meet the purpose of the act as you've outlined it?

A. No.

Q. No general notion?

A. It runs in the millions of dollars. I would not and could not guess.

Q. Now, you've stated that you've recommended expansion of these community services generally, but not in terms of each of the five counties; is that correct?

A. That's correct.

Q. Is there an amount, figure that you've recommended generally throughout the five counties for this expansion?

A. No.

Q. How, then, have you made the recommendation?

A. It's been based on the recognition and the knowledge of the number of, to use an example, of

[71] individuals in state centers, that if there were a

continuum of residential and support services in the communities, that in the future there might not be a need for state centers for the mentally retarded, if the appropriate services could be provided in the communities with the appropriate amounts of money to support that.

Q. I'm a little lost on how you've made this recommendation.

A. Okay, how I've made the recommendation.

Q. Right.

In other words, we were discussing, when we got under this line of discussion, budgets and recommended increases, and, I believe, you've told me that you have no specific number in mind as to the amount of monies required for such an expansion but on the outline of criteria that you've just given, that expansion is recommended.

Now, how do you make that kind of recommendation or how have you made it?

A. Those recommendations have gone to Deputy Secretary Hobbs.

Q. In writing, I take it?

A. Yes, both in writing and in discussion.

Q. When would the last recommendation in writing have been made?

A. They are of a general nature, and I don't have any specific date.

[72] Q. When you say "They are of a general nature," what do you mean?

A. Of a general nature, in that I define what I perceive to be inequities in terms of the present system.

Q. Determine inequities?

A. Yes, inequities.

Q. What inequities are you referring to?

A. The way money is allocated in the Commonwealth in terms of mental retardation.

Q. Allocation inequities, do you mean?

A. Inequities in the allocation of available dollars.

Q. What are the inequities of the allocation of available dollars?

A. The basic funding strain. There is a financial incentive that the counties have to institutionalize people.

Q. An incentive to institutionalize people?

A. A financial incentive.

Q. In the counties?

A. For the counties, because the state appropriation is Appropriation 40, which serves the Mental Health-Mental Retardation facilities, and that's 100 per cent state-funded.

Q. By that, you mean that if someone goes to an institution, the state picks up 100 per cent of the tab?

A. Correct.

Q. If they're in a community program, the state
[73] picks up 90 per cent of the tab; the county 10 per cent of the tab?

A. Basically, yes.

Q. I take it that the 100 per cent, if you will, picking up the tab is the incentive to institutionalize?

A. I've defined that as an incentive to institutionalize.

Q. "Yes" is the answer?

A. Yes.

* * *

[95] MR. PEABODY:

Q. Now, have we outlined completely, then, the budgetary process for the county community-based mental retardation programs?

It seems to me we got with a lot of detail to the legislature and maybe I'll recount it, going back through the system again and see if I caught it all.

The legislature passed a bill, an enactment or a
[96] form of the Executive budget request.

A. Correct.

Q. That bill goes back to the Executive budget office for allocation —
A. Re-allocation for rebudget.
Q. Right.

Specifically for rebudget in cases where the appropriated figure is fewer dollars than those requested; is that correct?
A. Correct.
Q. Now, is it that if the appropriated amount is the same as the budget request, no rebudget or re-allocation would occur?
A. I would assume that's correct.
Q. They just go with what they've proposed, I take it?
A. Yes.
Q. Then it goes back through the secretary's office, back to the budget office of DPW, where additional breakdowns are made?
A. There's an entire rebudget process. Each one of these offices will do a rebudget.
Q. At the budget office level, it would again take on the contours of the region and the counties therein?
A. Yes.
Q. And then, from the budget office, it goes to the
[97] central office, back to the regional office?

In the case of 40 funds, definitely to the regional office, then, I assume, to the institution; in the case of 43's and 57's to the commissioners with a copy to you so that you'll know how much the counties are receiving?
A. The regions and the counties get them at the same time.
Q. So the process I've outlined is generally correct; is that so?
A. Yes.

* * *

121A] BY MR. PEABODY:

Q. Now, Paragraph 3 asks you basically for the Title 20 Plan, Commonwealth of Pennsylvania, and any other documents which will reflect how state funds are being matched to those federal funds.

Do you have such documents in your possession or control in the regional office?

MR. COOPER: There is an objection to that part of third request which asks for the Department
[122] of Public Welfare budget requests. As to the remaining documents, which include the Commonwealth of Pennsylvania Title 20 Plan, the Executive budget for the Department of Welfare, enactments of the legislature designate the amounts of money appropriated for the operation of such department, which reflect Title 20 allocations, i.e. the matching the state and federal funds, and Act 256 and developmental disabilities appropriations administered by DPW, there is no objection made, but apparently these documents are unavailable in the regional office at this time.

Q. Dr. Rice, you don't keep, as part of your work, the documents to current Title 20 Plans?

A. State-wide plan?

Q. Yes.

A. (No response.)

* * *

[123] Q. Now, are the various county-operated community-based mental retardation programs receiving Title 20 federal funds?

A. Yes.

Q. Could you explain briefly how they receive them?

A. Commonwealth receives an appropriation for Title 20. There are various categories in which that money can be spent. That is allocated to each region, and money can be spent in specific categories,

within the Southeast Region, within those particular objects.

Counties submit requests based upon their identified needs translated into dollar amounts that are necessary to meet those needs by objects as defined by Title 20.

[124] Q. Is this pursuant to the budgetary process you've outlined already?

A. Yes.

Q. It's part of that?

A. Yes.

Q. Now, to your knowledge, has the Commonwealth of Pennsylvania reached its Title 20 ceiling?

* * *

[125] A. I'm confused by "reached their ceiling."

My understanding is that they spend the money that is appropriated to them.

Q. They spend all they can get?

A. That's my knowledge, yes. It may not be to the penny, but I'm sure they make every effort and do spend as much as is appropriated.

Q. Do you have a notion as to how much of these Title 20 funds find their way to the community-based programs in the Southeastern Region?

A. No, but I can get you that.

For what year?

Q. '76-'77.

That would be reflected, I believe, in the '76-'77 plan.

A. Right. You'll find that in one of those breakdowns by category, by region.

* * *

[126] Q. Do you have documents in the regional office, described in Paragraph 4, namely, reports as to the amounts of Title 19 funds received, for the operation of Pennhurst during the present and past two fiscal years?

MR. COOPER: Apparently the Title 19 infor-

mation is not kept in the regional office. I'm not certain whether it's in the central office or not.

Q. Do you have knowledge as to where these records are kept?

A. They would be in the budget office, and it's part of the money that is defined in those budgets were defined in augmentation, as you have seen.

Q. Title 20 monies would be reflected in the aug-

[127] mentation column of the Pennhurst budget requests that I showed you. Title 19.

Q. Pardon me, Title 19.

A. That's part of the augmentation.

* * *

[135] Q. In response to questions from Mr. Peabody, you went over the various categories of budgetary requests and allocations that you analyze.

These included the base allocation, the community living arrangements' allocation, the institutional allocation, those three.

Are there any other specific budget categories or allocations which you review?

A. There's an FRS, which is categorically within the base allocation, and there is what is defined as Pennhurst dispersal, which is part of Appropriation 43.

Q. Are there any other categories of budget requests or fund allocations?

A. There would be Title 20.

Q. Is Title 20 within the base?

[136] A. No. There would be Title I DD, developmental disabilities, and this will fluctuate from county to county.

* * *

[138] Q. You also mentioned developmental disabilities, which is identified as DDS allocation is budgetary documents?

A. Yes.

Q. What is that?

A. That is money to impact on the developmentally disabled, and the classification is mental retardation.

Q. What is the process for individual counties re-
[139] ceiving developmental disabilities' money?

A. Last year or this year? It has changed.

Q. Let's start with last year.

A. Last year the regions were told that there was approximately X amount of dollars that would probably be available for developmental disabilities. We in turn contacted the county MH-MR offices and alerted them to the fact there would be developmental disabilities', monies, gave them a package of applications, procedures, criteria; in turn, they received applications from providers. They screened the proposal at that level to make sure it met the criteria procedurally and programmatically.

They prioritized programs they wised to fund, if they had the money. That information was sent to the regional office. The regional office met with each of the counties regarding their individual priorities that came up with the regional priority.

Based upon that priority around that particular time, the region is made aware of the amount of funds and we allocate it appropriately.

Based on the priorities and documentation of need —

Q. Who set the priority for allocations?

A. Initially it came from the county, and then there were negotiations between the region and the
[140] county as to the particular needs.

Q. Do you recall what the total amounts of funding, developmental disabilities' funding, for the last year was?

A. Initially — I'd rather get you — it was not a lot of money. There was much more effort put into it than money received.

Q. Generally a hundred thousand; a couple hundred thousand?
A. A hundred thousand.
Q. Do you recall what the priorities were in the expenditure of that?
A. The priority was to support individuals who were in community living arrangements' programs or in similar types of situations, living arrangements.

[27] **M. Knowlton — Deposition**

* * *

Q. You say you plan for different types of Community Living Arrangements. What are the types of Community Living Arrangements?
A. What are the types?
Q. Yes.
A. As I said earlier, there are currently seven types. The first type is what we call a Developmental Maximation Unit. That is a —
Q. Why don't you just tell me what the types are, first. You said there were seven types?
A. Right. That's the first type.

The second type would be Intensive Habit Shaping; third type is Structured Correctional; fourth type would be Child Development; fifth would be Adult Training; sixth Adult Minimal Supervision; and seventh would be Family Relief.
Q. Before we get into these types, is there a generic definition or description of Community Living Arrangement?
A. As a whole?
Q. Yes.
A. I don't think anything specific, other than residential facilities in a community that would offer
[28] the least restrictive environment, living environment in the most normalizing setting.
Q. They are basically residential programs as opposed to service programs?
A. The primary emphasis is residential, but in some areas there are specialized needs that have to be fulfilled through particular types of services being rendered to meet the needs of the individual.
Q. What types of clients does CLA serve in terms of age and developmental level?
A. The continuum of seven programs offers residential settings to all individuals that are mentally

retarded, no matter what their functional level and no matter what their age. Or secondary handicaps, for that matter.

Q. Are individuals excluded from Community Living Arrangement Programs in terms of any particular behavioral characteristic or disability?

A. On occasion, but not because of their disability that much, more so because the particular program that they may need is not available in the particular county, and they may have been improperly selected and gone into a community program and found out that that was not the appropriate program, so they may have been asked to leave because of that, gone to another setting.

Q. That is because a particular placement did not work out?

[29] A. Work out.

Q. But there are no prior criteria which could exclude a person from a Community Living Arrangement?

A. No.

Q. Community Living Arrangements serve both people who are now in the community and people who are in the institutional programs?

A. That is correct. We are looking at two things, one would be de-institutionalization, and two would be prevention. So we have had a basic policy over the past three or four years recommending that 50 percent of the residents come from the community and 50 percent of the residents come from the institution.

* * *

[54] Q. Earlier on you described the various types of Community Living Arrangements. You named then the various Community Living Arrangements. First was Developmental Maximation Unit?

A. Yes.

Q. What is that?

[55] A. That's a program that would serve either adults or children that have a primary medical need. That would be medically complex or multi-handicapped.

The major responsibility would be to work on the medical problem first, and secondarily, on going working to teach developmental skills to the individual.

Q. Is there a particular age range that this —

A. Well, the age range would be from birth to death, but we would divide children and adults, they wouldn't be in the same facility.

They could be any functional level. Again, the primary need would be medical.

Q. Would these be the people who are generally described as the more fragile and more severely impaired?

A. Well, it you are talking about physically fragile, yes. Again, it's physical problem. An individual could be profoundly retarded but not need or not have a need for medical type back-up.

* * *

[56] Q. How many people would one unit serve?

A. That could vary depending on how the county wants to operate the particular program. It could be anywhere from two to twenty, even thirty.

Q. Is there a maximum number?

A. The maximum number that we have set is twenty, but we have waived that in one instance and we are probably revising that in our regulations that we are currently revising now down to a lower number.

Q. What is the purpose of having a maximum number? For example, Pine Hill serves 150, 160 people.

A. Well, our concern was based on some pragmatic concepts as far as the larger their program the harder it would be to manage it, perhaps. We wanted more individualization, more normalized

living. Again, for the same people, as our trend
[57] throughout, offering the least restrictive type of living situations. We came to the conclusion that people that have that kind of need for residential services don't have to live in nursing home or medical facilities if they have the appropriate staff support in more normalizing and more integrated living situations.

Q. Is there evidence that a smaller facility makes a difference in terms of the growth development of the person and the care of the person?

A. Well, we are currently working with one provider in Montgomery County now, Lynch Home, which you may be familiar with, where they have in a home-like situation individuals that are medically complex, multi-handicapped, children, in fact, and we have recently funded them to disburse those same individuals with staff into smaller living units, apartments, things like that. The individual responsible for that program, who has had that particular program responsibility for many years, feels very clearly that, based on his experience and knowledge of working with these kind of people, that the less structured living situation would be much more appropriate to meet the needs of the individuals that he is currently serving.

Q. Are these types of people that you are describing in the Lynch Home the types of people that formerly would have been committed or admitted to Pennhurst or another institution for long-term care?

[58] A. They more than likely would be, if no other facility was available, because they have many severe kinds of medical problems and abnormalities.

Q. Were facilities like the Lynch Home available in April of 1972?

A. The Lynch Home itself was, yes.

Q. How many people did it serve?

A. I don't know. I would — I'm guessing somewhere between 15 and 20, though.

[60] * * *

Q. Another type of Community Living Arrangement you mentioned was Intensive Habit Shaping?
A. Right.
Q. What type of facility is that?
A. This again is broken into adults and children's units. This is to serve individuals that have severe acting-out behavioral problems, personal problems such as head banging, window breaking, a lot of emotional kinds of disorders. They are personally related. Severe toilet training problems, severe feeding problems, things of that nature.
Q. What are the characteristics of that type of facility in terms of staffing and program operation?
A. Well, there can be three different models for that type program. The one that we are most familiar with and have the most of now is generally a six-bed unit that would be staffed with people that are skilled behavioral therapists with a primary responsibility to extinguish the negative behavior and replace it with something positive. So the six-bed unit, that would be one.

Another type of facility would be an apartment facility with one or two children in an apartment and again, behavioral therapists living and working in the apartment with the children.

A third component would be moving the person that had those kinds of problems into a non-specialized program and having a core staff of behavioral therapists working with the staff and child, using a child as an example here, in a non-specialized program till the negative behavior was extinguished

[61]

and replaced with something positive, and then the core staff would leave and go somewhere else.

Q. Are there proven therapy or treatment techniques to modify behavior such as head banging, self abuse and in acting-out behaviors in retarded persons?

A. Things like behavior modification and other programs like that would extinguish that particular behavior. Another precision measurement, precision teaching, all fall into that same category.

* * *

[62] A. Well, right off the bat there is one that is funded to be a habit shaping in Philadelphia.

Q. Are there any in operation?

A. That one is, it's funded and in operation.

Q. It has people?

A. It has a Habit Shaping Unit, yes.

Q. Is that a six-bed unit?

A. Yes, for adults.

Q. The Habit Shaping Unit requires a particularly skilled staff component?

A. That's correct.

Q. Do these staff have to be hired by the county?

A. The staff have to be hired by the agency that contracts with the county, unless the county is providing the program themselves, then they would hire the person.

Q. Is the availability of staff any particular barrier to setting up this type of a home?

A. Yes, it is. It's one of the major barriers as far as the availability of skilled staff.

Q. This would be one of the program components that is 100 percent State funded, though, is that correct?

A. All of the Community Living Arrangement programs are 100 percent State deficit funded.
Q. The third type was Structured Corrective?
A. Structured Correctional.
[63] Q. What type of facility would that be?
A. This would be to serve individuals that had anti-social behavior, maybe potential or actual offenders. It could serve children or adults, but in separate facilities.
Q. Are there any particular program or staff requirements of this type of facility?
A. Well, we require that the responsible person for the development of a program have skills in dealing with anti-social behavior, have some kind of background in dealing with either adult or juvenile offenders.
Q. Are there any particular facilities constellations for this Community Living Arrangement?
A. We basically offer the same three settings as we did with the Intensive Habit Shaping; single homes that may serve six people, apartments that would be integrated and disbursed or a core staff with the individual, again, like Intensive Habit Shaping, be integrated into a non-specialized program with the core staff working with a regular staff and the resident.
Q. The next type you mentioned is Child Development?
A. Right.
Q. What type of facility is Child Development?
A. This would be a basic children's residential program for individuals from approximately birth to age, again approximately, age eighteen, and would
[64] serve those individuals that do not need a more specialized living situation but are basically there to learn developmental skills, social skills, and our direction here is to develop this particular setting as close as a normal home-like setting as possible.

Our primary emphasis is on small apartments or small homes, husband and wife teams and two or three children that would be operating that particular type program.

Q. These homes, the husband and wife team are actually the staff of the home?

A. Well, yes, but there are instances where there would be other staff that would be working part-time. In fact, the husband or the wife, either one of them could have outside jobs, but one would be responsible as a full-time employee. Generally it's the husband working out.

Q. What are the size of these homes or the size —

A. Well, of homes?

Q. How many children live in these homes, numbers?

A. Be more specific as far as the total amount of children in CLA or the amount we would allow in one home?

Q. The amount you would allow in one home.

A. A maximum of eight and that's very rare now. We are almost predominantly going to staff departments where we have generally two children. That's the preponderance of the children's development program.

[65] Q. Two children in one home or apartment staffed by a husband and wife team?

A. And any assistants that they may need.

Q. Children of these homes go to public school, generally?

A. Almost universally, except for some instances where the children may not be of school age. Then they would go to early childhood development class, pre-school.

Q. Those persons at Pennhurst between four and a half and eighteen of school age go to school during the day and then return to Pennhurst and receive

educational programming. What basically are the benefits of a child living in an arrangement as a Child Developmental Community Living Arrangement than living at Pennhurst?

A. Well, an individual as a child would have much more individualized attention because in most instances there would be one or two or even at the maximum eight, and the whole living situation would be much more normalized as far as the living situation within the home, within the community; as far as the individual would go to school within that community and go back to the home within the community; all services as far as dental, medical, religious, everything else that person normally receives in the community, this same child in the CLA programs in the community would receive. They would go out to the store with the
[66] houseparents and buy clothes and go to the market, buy food, go the barbershop in the community and get their hair cut, just lead the same type of life any other child would lead.

Q. Aren't there services that might be available to a person in a large institution that would not be available in the community, such as physical therapy or occupational therapy or medical services, all those services that you mentioned are available to any other person in the community?

A. I don't see where they wouldn't be available to someone who is mentally retarded.

Q. Do children living in Community Living Arrangements, in fact, receive these services?

A. I can't guarantee that everybody receives it, but it should be there. It's as good as our monitoring ability.

Our own accountability system, we ask that there be annual medical check-ups, dental check-ups; quite a few people that receive speech therapy

in CLA program and other kinds of therapy.
Q. The Community Living Arrangement that is typed as Adult Training, what is that?
A. That's for individuals that are age approximately 18 and over who would receive training in a residential setting to aid them in becoming more socially adapted within the community, give them homemaking skills, cooking skills, basic skills that
[67] individuals as adults would have to have to be able to live more independently in the community, communications skills, how to use telephone, transportation.
Q. How are these facilities staffed?
A. They are primarily staffed with adults who, in some instances, may be husband and wives in group homes and other instances may be husband and wives in apartments, or they may be staff of one sex; male programs might be males or females might be female staff. It doesn't necessarily always have to be a husband and wife team for adult programs.
Q. Are there a maximum number of persons to each facility on that type of living arrangement?
A. The maximum number is eight. Again, the numbers are going down as far as that type of setting. We are emphasizing smaller staff programs such as apartments for the adults as well as the children.
Q. Are these adults also in various programs in the community, service programs in the community?
A. We would expect the adults to be in vocational training programs on competitive employment.
Q. Is that a requirement of the program?
A. Yes. In fact, in our proposal format we have one page that a provider must fill out that specifies all the supportive services that are going to be available and who is going to provide them and who is going

to pay for them; medical, dental, religious, day programs and so on.

[68] Q. In other words, a provider could not provide an adult training living arrangement which would simply provide shelter and room and board for the adult and the adult might be sitting there all day?

A. Generally not, but in a few occasions it might be possible. Some examples would be there may be an individual that would come into CLA that's elderly and it may not be appropriate for that person to work, and that person may make the decision that he or she doesn't want to work and does want to stay at home and just interact on their own in the community or in that particular home.

Another example would be the case where an individual might come into a Community Living Arrangement program as an adult, enter a vocational training program and go through a year or two years in a vocational training program and all of a sudden the money might run dry to support him, and the person might have to sit home for a certain amount of time until the day program money went back into the particular vocational training.

Q. Those are individual circumstances. You would not approve of a home which would have, for example, eight adults without a program, with no activity?

A. No. Every program would have to offer something.

But to clarify a little bit more, quite possibly in some instances the individuals may not leave the

[69] home for the service. For example, the Developmental Maximation Unit, we may have to bring staff in there because the individuals' medical problem wouldn't allow them to leave the building.

Q. I was talking specifically about the Adult Training.

A. The Adult Training, they should not be at home other than the earlier reasons I gave.
Q. Adult Minimal Support?
A. Minimal Supervision.
Q. I'm sorry, Adult Minimal Supervision.
A. This is for individuals that are about one or two steps away from complete independence. In other words, no longer need State support or county support their living situation. They lack perhaps one or two basic skills, such as cooking or money handling, before they can live completely independently.

The primary responsibility there would be to concentrate on developing those particular major skills that are lacking and have the person leave the CLA program completely and live on their own.
Q. What type of staff do you have in the Minimal Supervision?
A. This would vary depending on the needs of the individual. It can be a living situation where two or three people that would be considered minimal supervision would live in an apartment with one
[70] person that was staff that would kind of work with them. Then as those people would develop their skills, the staff persons may leave or those residents may leave and move into some other apartment where they might only be visited by a staff person. Again, then depending on their needs it could be daily, it could weekly, it could be monthly, depending on how they progress.
Q. Is there a maximum number of individuals in each one of these programs?
A. I can't think of anything over six without, and generally that's two or three.
Q. I take it that there are people who enter into Community Living Arrangements, reside in those Community Living Arrangements for a time, then

move on either to independent living or to another type of —

A. Something less structured.

Q. Something less restrictive, is that the case?

A. Absolutely.

Q. Do you have any figures which would indicate how many people have moved from Community Living Arrangements to less structured —

A. That's on our monthly population report, to a certain degree, not exactly within the system. We don't have that movement, but we have the movement as far as people that come into CLA and then leave.

[71] I mentioned earlier we have 2,260 people in CLA at the end of January. CLA has served totally since April of 1972 almost 4,000 people. Now, of that difference, then, a good many of the adults have gone on to live independently. Many children have gone on to live at home, back with their family. In some instances some children have gone into foster homes.

We have had about 200 individuals, as an approximate, who we were not successful with in CLA and have gone back to public institutions.

Q. Have some of these individuals that have either moved to independent living or to live with their family or foster care, individuals who originally came from institutional programs?

A. Many of the individuals that have gone on to independent living were from institutional programs, but I don't have any specific breakdowns. I think the best thing I can give you there is just from my own experience in Nebraska when I was operating programs, that the people that seemed to benefit fastest and move faster through the program, whether it be into competitive employment or independent living were generally those people from in-

stitutions. They seemed to do much better than people from the community.

Q. Is that due to any particular aspect of the Nebraska program or to what do you attribute that?

A. I attribute it to perhaps two things; one, it would
[72] be the work that the institutional staff did with the residents and secondly, it appeared that many of the residents that came from institutions really didn't have to be there if something more appropriate was available. So it was, what we offered them was, they were just ripe for you know, rapid growth and development because we did give them access to —

Q. Do you have any reason to believe the situation is different in Pennsylvania?

A. I don't see anything that would tell me that it would be different.

Q. Any reason it might be different in Southeastern Pennsylvania?

A. No.

* * *

[73] Q. If there were no admissions to Pennhurst or commitments to institutions in the Commonwealth, would one of these types of Community Living Arrangements provide an appropriate residential placement for those individuals?

A. Yes. One of the seven, yes.

[102] Q. Of the over 2,000 people in Community Living Arrangements, do you have a breakdown on developmental level?

A. No.

Q. And entrance into the programs?

A. No, but —

Q. Do you have any basis for knowing what that is?

A. You can generally tell by the type of program.

If it's Intensive Habit Shaping, you can pretty much know that it's severe and profound.

Developmental Maximation Unit is generally severe and profound.

[103] The Adult Training would be generally severe and moderate.

Adult Minimal Supervision would be high moderate, mild. So there's patterns based on the type of program.

* * *

Supreme Court, U. S.
FILED
OCT 30 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408,
79-1414, 79-1415, 79-1489

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Pennhurst State School and Hospital, et al., *Petitioners*

v.

Terri Lee Halderman, et al.

Pennsylvania Association for Retarded Citizens, et al.

and

United States of America, *Respondents*

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

JOINT APPENDIX — EXHIBITS VOLUME VI, A943-A1166

Petitions for Certiorari Filed March 12 and 20, 1980.
Certiorari Granted June 9, 1980.

THE LEGAL INTELLIGENCER, 66 NORTH JUNIPER STREET, PHILA., PA. 19107 (215) 561-4050

EXHIBITS*

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PARC Ex. 26	Press Conference, Secretary of Public Welfare, Wohlgemuth, 12/14/72	A971
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PARC Ex. 33	Need and Assessment and Budget Projections on Deinstitutionalization of Montgomery County persons residing at Pennhurst Center	A983

*Exhibits included herein were admitted into evidence at Tr. 1-36 to 1-43; and Tr. 1-49 to 1-56 and at Tr. 4-68.

EXHIBITS* — *(Continued)*

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PARC Ex. 38	A Brief History of Pennhurst, 1908-1926, Compiled from Superintendent's Records	A988
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PARC Ex. 58	Allocations, Expenditures, and Carryovers of State Funds for MH/MR	A1020
PARC Ex. 63	Definitions of Community Living Arrangement Types	A1029

*Exhibits included herein were admitted into evidence at Tr. 1-36 to 1-43; and Tr. 1-49 to 1-56 and at Tr. 4-68.

EXHIBITS* — *(Continued)*

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PARC Ex. 64	Community Living Arrangements Population and Dispersal Report — June 1976	A1032
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U.S. Ex. 5	Pennhurst State School and Hospital — Memorandum, May 15, 1975, Inappropriate Commitments	A1153
U.S. Ex. 15	Pennhurst State School and Hospital — Cumulative Accident Summary December 29, 1976 — January 29, 1977	A1157
U.S. Ex. 48	Index of Photographic Exhibits of Pennhurst and Community Programs	A1161

Photographs admitted into evidence as U.S. Exhibit 48 are presented in a separate volume.

*Exhibits included herein were admitted into evidence at Tr. 1-36 to 1-43; and Tr. 1-49 to 1-56 and at Tr. 4-68.

A943

PARC Ex. 18

Commonwealth of Pennsylvania

The COMPREHENSIVE MENTAL RETARDATION PLAN

December 1965

39] *Away from Custodial Care*

Fewer than two percent of the residents of Pennsylvania's state schools leave the rolls each year; and half of those by death, rather than by discharge. A discharge rate of less than one percent has two implications: First, that beds are not opening up for persons in the community who need them; and second, that the state institutions continue to provide a program that barely rises above purely custodial care, if it rises at all.

The low discharge rate is partly due to factors external to the schools. It has proved highly difficult to find a place in the community for persons who need protection, and who must compete for scarce jobs with intellectually more gifted individuals. Only limited action can be taken to correct such problems, e.g., establishment of urban "halfway houses" for vocationally trained youngsters.

But vigorous steps can and should be taken to provide programs within the state schools that will help residents develop to the limit of their capacity as human beings. These programs will require strong state financial support, during the transition from traditional custodial care.

Diagnosis and evaluation has been provided in Pennsylvania, as elsewhere, primarily in academic or independent centers oriented to professional training and clinical demonstration. The exceptions have been three state-supported diagnostic and evaluation centers for the mentally ill and mentally retarded which, as screening agencies for applicants to the state schools, have served a fraction of the retarded population.

The time has come to develop diagnostic and evaluation centers to provide services corresponding to needs. A more pressing need appears to be the need in the diagnosis of the severely retarded and infant retardates to permit correct diagnosis and early treatment. The state schools can have a major role in such services.

They are situated in largely rural areas, remote from the urban centers where services are more plentiful. (And, uniquely in their areas, they have or should and will have) staff representing the entire range of professional skills needed for diagnosis and evaluation.

The state schools, therefore, should be considered as prime locations for diagnostic and evaluation services. Moreover, they are logical "home bases" for traveling professional teams set up to carry on diagnosis and evaluation in more remote communities, and to train professional and community leaders there to recognize signs of possible mental retardation.

Within the state schools there is pressing need for systematic *to evaluation* programs. Too many residents have entered the schools and become lost inside, in effect, going for years at a time without re-examination. This is borne out by the fact that 2% of the residents in state schools do not have a level of retardation reported

and 1% of the residents in state schools are reported as having no retardation.

Many of the institutions are establishing yearly re-examinations. Even this may not suffice for youngsters who "grow" rapidly in training or educational programs.

State schools should consider providing *short term residential* care for three different purposes.

First, short term care should be available with diagnostic and evaluation services. Some individuals need observation over a longer period of time to be adequately evaluated.

[10] Second, short term admission should be available for "parent relief", to help families of retarded individuals over family crises or to allow parents a needed vacation from the 24-hour care of a retarded child.

Finally, short term admission should be available to retarded individuals who can profit from brief periods of intensive services; for example, a rural child who might be unable to attend regular speech clinics, but who could profit from several weeks of daily speech therapy.

To provide short term care, the state schools need revised statutory regulations covering their admissions.

If the *long term focus* in the institutions is to be replaced by short term focus, including parent relief, the effect of this will be longer waiting periods for admission unless discharge rates are shortly increased or facilities for schools are markedly expanded.

The state schools should study a plan being tested in Missouri in which parents are asked for reasons why they need to place their child. The state then tackles the needs from both ends; by seeking to habilitate the child, and by arranging to have social services applied to family problems. If and when the reason for placement is removed, the child is returned to his home.

In the program, long term care serves a function similar to that of "emergency" short term care, but extended over more time; that is, to help the family over a crisis that is preventing it from providing for the retarded child.

A946

PARC Ex. 21

THE 1969 and 1979 PENNSYLVANIA STATE PLAN FOR THE CONSTRUCTION OF FACILITIES FOR THE MENTALLY RETARDED

Volume I

Department of Public Welfare
Mental Health and Mental Retardation
Division of Planning, Evaluation,
and Community Programs

[11] III. *Program Goals and Objectives*

Comprehensive planning for the mentally retarded in Pennsylvania is based upon the principle that all programs should increase the opportunity for each retarded individual to attain his fullest potential. It is clearly recognized that a comprehensive and diversified program of community based services accessible to the retarded and their families is the basic goal underlying the Commonwealth's planning effort. Such community programs would include preventive services; diagnostic clinics; nursery classes for pre-schoolers; parent education and guidance; recreation; vocational training and sheltered work experience; job placement and follow-up; halfway houses; group homes and short-stay provisions, as well as other types of community care for the retarded. Maximum utilization and coordination of general community health and welfare services is recognized as of primary importance.

The Commonwealth's planning program, therefore, conceives of program and service development in terms of both specialized and general services. Based upon the problems and needs of the regions and administrative units herein defined, the Commonwealth of Pennsylvania accepts responsibility for providing leadership and

the allocation of resources toward the development of essential community services for all ages of retarded and levels of retardation through the establishment of both special and general services.

In addition, it is also a firmly established goal that those retarded individuals in need of residential care away from home will have available to them the best quality of care, which, when possible, will be directed toward rendering such individuals capable of community living.

The development of necessary services and facilities for the retarded in Pennsylvania will be based upon a thorough knowledge of the extent of mental retardation and related resources. Based upon a planning program which has evaluated current and future needs, the Commonwealth of Pennsylvania will make a concerted effort to combat mental retardation through a programmed development of resources for this purpose.

The Construction Plan for Mental Retardation Facilities will serve as a basis for allocation of Federal funds available under Title I, Part C., P.L. 88-164. Construction priorities will reflect current needs and will serve as a guideline for the establishment of effective services for the diagnosis, treatment and care of the mentally retarded.

* * *

A948

PARC Ex. 25

April 12, 1972

Proposed Expenditure of All Capital Funds for Pennhurst — Supplement (Questions raised regarding the proposed total dispersal of that institution by the end of fiscal year 1974-75)

William B. Beach, Jr., M.D.
Deputy Secretary for Mental Health and Mental Retardation

Edward R. Goldman
Commissioner of Mental Retardation

1. What is being done to spend the Act 256, G.S.A. 523-1 funds authorized for logical dispersal and reorientation into the community of 900 Pennhurst residents:

Phase I of this project has already been completed. The scope of Phase I was to determine the type, size, and recommended location of community facilities required to provide definitive treatment and normalizing accommodations for approximately 000 persons currently in residence at Pennhurst. To accomplish Phase I, a project director and staff of eight persons were employed for six months to conduct a demographic study and social systems analysis of the institution and the five counties served by it. The results (Region I Planning Project, attached) have been distributed for review and accepted by the five concerned County Mental Health and Mental Retardation Program Offices. Approximately one year ago, the Southeast Regional Office was requested to secure written acknowledgment of this acceptance by January 30, 1972 so that G.S.A. might proceed to acquire and construct/renovate the necessary facilities. G.S.A. has already ap-

pointed the architects and the Regional Mental Health and Mental Retardation Director is currently scheduling meetings with each concerned County Office of Mental Health and Mental Retardation to secure the necessary written authorizations.

We understand G.S.A. can proceed immediately with the design and construction phases once this authorization is received from the Department. It might expedite matters if the Department could reinforce the already expressed need for immediate Regional attention and follow-through.

2. Timetable to spend the funds:

Act 256 stipulated that the project was to be completed as expeditiously as possible so that the first units might be occupied not later than two years from the effective date of the Act (by November, 1972). Although Phase II of the project has been unfortunately delayed, there is no danger that the funds will be lost. The Department's legal office has advised us that this stipulation is directory in nature, not mandatory. (Time Limit on G.S.A. Funds for Dispersal of Pennhurst, attached). It is reasonable to expect that, since the units in question are not the large traditional institution-type facilities and that four architects have been appointed to ensure that Phase II might proceed simultaneously across the region, the project should be completed by the end of fiscal year 1974-75. A more specific timetable will be contingent upon the capacity of G.S.A. to honor the directory stipulation "as expeditiously as possible" and the Department might do well to remind G.S.A. of the urgency of this project when it forwards the written authorizations to proceed.

[2]

3. What steps must be taken to spend the funds:

A. The County Mental Health and Mental Re-

tardation Program Office's written submission of approval must contain a finalized listing of the specific types of units appropriate for each County in terms of each County's developing program plan for a continuum of mental retardation services, and at least the approximate geographic location for each type of unit to be renovated/constructed.

B. Once secured, the above information must be forwarded to G.S.A. with a request by the Department for all due haste in follow-through.

C. It has already been recommended by this office that G.S.A. be requested to appoint an *on-site* special coordinating architect for the Southeast Region to expedite the follow-through and to synchronize the simultaneous activation of construction/renovation in five counties. We have been assured by a consultant architect that by coordinating the design phase, sharing design and construction information and materials and "riding herd" on the process to eliminate unnecessary hang-ups and waste of time, the Commonwealth could save both time and money. Although this request was not considered feasible by our management office and the G.S.A. when originally made, we suggest that it be reiterated with the submission for the Department's authorization to proceed.

4. What is the County's role in the program to be provided in the facilities and in their planning:

These units are to become a permanent and integral part of each County Program's planned continuum of mental retardation services and the County Program, through its Base Service Unit mechanism, is responsible to:

A. Assess the condition and circumstances of each Pennhurst resident prior to his proposed relocation;

B. Prepare individual life-management plans for each person to be so placed, including a definition of the special purpose to be served by the placement;

C. Establish an individually appropriate and realistic personal development goal to be accomplished for each person by each such placement;

D. Maintain regular liaison with the unit to ensure:

[3] (1) that time spent in residence is limited to the time required to accomplish the established goal; and,

(2) that service provided by the facility is consistently more suitable than the person might receive elsewhere in the community.

E. Establish a counseling/planning relationship with each unit, each resident's family, and the resident himself when possible to expedite the achievement of optimum independence for each resident;

F. Prepare post-release service plans and develop County Program post-release services and resources as indicated for each resident; and

G. Assume fixed follow-along responsibility for each resident and his family as required.

In keeping with its responsibilities to the persons being served by these units, the County Program Office will perforce be the determiner of each unit's service role and the coordinator of each unit's function as a unit of service which is to be part of a continuum of community-based units of service, which all together will constitute the "program." The residential unit is not in itself

to be considered a program; it's to be a structured living arrangement, not a small total institution geographically located in the community. In order to integrate these residential units socially as well as physically into the community as mandated, the County Program must simultaneously expand existing and develop new non-residential community services to meet the educational, training, recreation, and work requirements of each resident as his capacity for self-care, self-sufficiency, and self-support increases.

5. Where in the County will the facilities be located:

Each unit must be located where its residents will secure optimum benefit from non-residential community services and resources and in keeping with each County Program's plan to develop a comprehensive mental retardation service system. The Region I Planning Project study provides suggested locations based on a social systems analysis of each County's current resources. The County Program has an option either to adopt these location suggestions or to revise them more in keeping with its own planning projections and the realities of its local situation.

6. What programs will be carried out in these facilities:

See answer to Question 4. It is expected that each unit will provide program in keeping with the service objectives and requirements of the residents it currently serves. As the residents develop greater competence and their needs change, the program should also develop and change. As the social competence of each resident increases to the degree that he can return to his own home or move to another less structured living environment, the unit's program should be updated in terms of the replace-

ment residents referred to it. A rule of thumb for programming is the more sheltered the environment, the more structured the program. Less competent persons require more intensive and more continuous training and education. No referral to a residential unit should be considered a dead end, even if the placement is for an indeterminate length of time.

[4] 7. Where will operating funds come from:

The existing Pennhurst operating budget can be deployed into the operation budgets of the new units:

A. Units that are primarily for persons who require health care and medically-supervised personal care more than any other service will be constructed/renovated to meet Federal skilled nursing home and/or intermediate care requirements. Operating funds for these units will be a combination of Federal MA and State funds.

B. All other type units will require State operating money to the degree that we cannot secure 75-25 federal social service reimbursements. It is anticipated that as a minimum, we will be able to secure such reimbursement for all services provided on these premises except for food and maintenance.

8. Construction Timetable, completion and occupancy:

As already discussed under questions 2 and 3, the details of the construction timetable are contingent upon G.S.A. capacity to follow-through after authorization. They are also contingent upon County Program decisions, whether to construct or renovate. It is recommended that, as much as possi-

ble, existing structures be utilized. They are more normalizing and can be more quicky readied for occupancy than new construction. They should also be less expensive and can be readily abandoned and sold, should the population base change and their program useability deteriorate. Despite our inability to pre-determine the specifics of the construction timetable at this time, completion and occupancy should reasonably be expected by the end of fiscal year 1974-75.

9. Implementation of dispersal with timetable:

The Department should request a construction/renovation timetable from the architects with its submission of the authorization to proceed. When this is available, it will then be possible to chart the implementation of the dispersal with a timetable.

10. Who will be selected to return from the institutions — first and thereafter. Who will make the selection and what will be the role of the County Program:

In this instance, to expedite a long overdue resolution of the hazardously overcrowded Pennhurst situation, the institutional staff, in conjunction with Planning Project staff, conducted a demographic study of the institution's population and made the selections, in keeping with a concommitant Project team analysis of the potential of each County's social service system to support the dispersal process. In the future, County Program staff, Institutional staff, consumer representatives, providers of community services, representatives of public and private resource agencies, families of residents and retarded persons themselves should all participate in the selection of persons to be reoriented into the community. In the future, the Regional Office should be responsible to coordinate this selection

and planning process and the County Program must be given decision-making authority commensurate to its delegated responsibilities.

[5] H. If Pennhurst is phased out:

a. how will all services (support) for a large institution be geared to one building;

b. what will happen to all present employees; and,

c. what will happen to land and buildings.

a. Assuming that it can be justified as sensible to keep, the new building in use as a residential service after the proposed total dispersal, previous engineering evaluation of the Pennhurst support services seems to indicate that: (Proposal for Renovation of Utilities, Pennhurst State School and Hospital, January, 1971.)

1. The existing, outmoded, deteriorated and uneconomic boiler plant could be abandoned and a small packaged oiler boiler unit with gas standby added to serve the single building. This would provide adequately for heating and air conditioning at a roughly estimated cost of $250,000.

2. The existing electric substation and wiring as it stands is adequate to serve the new building with its reduced population (168) with no further capital investment. An option would be to have Pennsylvania Electric install a new substation to serve the new building and abandon the existing one. Estimates can be secured to determine which is the more economical alternative for the Commonwealth.

3. Since water as currently supplied from the three remaining operative wells out of an original number of eight is considered inad-

equate, non-potable and undependable, it would be more economical to abandon the remaining wells and purchase water from the local community.

4. Dietary facilities as they stand are adequate to serve the reduced population (168) of the new building.

5. The inefficient, outmoded, deteriorated laundry culd be abandoned at a savings. It would be more economical to purchase commercial laundry service for 168 people than to renovate, reequip, and staff the existing utility.

6. When the necessary installation ($50,000) of a lift station now in process, is complete (pollution citation because of the dairy complex) the existing sewage facilities will be adequate for the reduced population of the one remaining building until such time as the new building can be hooked into community sewage disposal as planned. This would ultimately be more economical.

In general, it seems that the deteriorated, outmoded and wasteful operating condition of the majority of the Pennhurst support services eliminates the possibility of there being any problems connected with gearing these utilities into service to the reduced population of the single building, assuming that continued use of this building can be substantiated.

[6] b. The majority of Pennhurst's existing professional and direct service staff (approximately 900 persons) could be absorbed by Embreeville and by the projected residential units to be established in the communities (particularly by Health Care Facility types I and II). Placement of the remaining support service staff (approximately 600 persons)

would probably require systematic, planned intensive placement and job development efforts on the part of the Department. The problem of relocating the 1,511 person Pennhurst fixed staff complement might also find a solution in the retraining and job possibilities inherent in the pending takeover of Pennhurst's farm by the Department of Agriculture in 1973.

c. The Department of Agriculture is currently developing long overdue innovative new directions for enriching health, social, recreation and employment opportunities for Pennsylvania's rural population. The Pennhurst campus might prove to have valuable potential for future use as a rural resource development site. The farm, modernized, properly equipped, adequately staffed, and efficiently managed, could be a nucleus around which improved and new uses for rural land might be explored and new rural careers and manpower development programs developed. The Department of Agriculture is concerned to improve the life style and living conditions of the same citizens who are the primary concern of this Department. It is recommended that this Department and the Department of Agriculture together begin planning now for a combined approach to a new constructive career for Pennhurst.

A958

April 7, 1972

SUBJECT Proposed Expenditure of All Capital Funds for Pennhurst

TO William B. Beach, Jr., M.D.
Deputy Secretary for Mental Health and Mental Retardation

FROM Edward R. Goldman
Commissioner of Mental Retardation

The various available and projected capital investments for Pennhurst total $38,094,000 through fiscal year 1973-74. (Various Available and Projected Capital Investments for Pennhurst attached) A pending request to amend Act 256 by consolidating renovation Projects Female 1; $2,300,000; Female II, $2,300,000; and Utilities, $2,678,000 will add $822,000 to this total if honored. The total proposed investment is therefore $38,916,000; $21,079,000 to be invested in the community to serve 959 persons (Act 256 Pennhurst Dispersal Projections attached), and $17,837,000 for minimal on-site renovations intended to protect the lives and improve conditions for Pennhurst residents during and after the pending reduction in population from 1,799 to a maximum allowable census of 760.

Recent events now invalidate the proposed on-site investment of $17,837,000 and it is necessary to update this proposed expenditure in terms of Chapter 34 requirements; the Department's recent (December, 1971) architectural reassessment of Pennhurst's physical capability to meet basic skilled nursing home criteria; and the recently acquired option to transfer 600 Pennhurst residents to Embreeville by the end of fiscal year 1972-73. It would be fiscally irresponsible for this program office to permit the Department to proceed with these on-site projects as proposed without such a reassessment.

Today, after 69 years of existence and capital investments totalling $25,289,854 (Capital Assets Ledger List-

ing and Summary of Completed Renovation and Construction Projects attached), Pennhurst is apparently a total loss to the Commonwealth as a mental retardation service resource. All of its buildings, including the brand new $6,427,371 Hyperactive Children's Building, violate minimal health, social and safety standards and are totally unsuitable for modern mental retardation program purposes. It cannot earn a single dollar in Federal Medical Assistance benefits and its maximum allowable census has recently been reduced *to 616 residents* after required renovation costs of $13,733,980 although it currently houses more than 1,600 persons. (Pennhurst — Current Maximum Allowable Census, etc., attached)

[2] Renovation costs to existing resident housing have escalated in direct proportion to the Chapter 34 requirements, and the reduced maximum Allowable Census ratings of our basic skilled nursing home criteria. In addition to the $13,733,980 now required for resident housing another sum of $8,069,542 is considered necessary to upgrade support and program facilities. (Plan B, Master Facilities Plans A, B & C, Pennhurst State School and Hospital, prepared by Bureau of Construction and Maintenance, July, 1971) This total sum of $21,803,522 is $3,966,522 greater than the on-site capital renovation investments of $17,837,000 originally proposed as minimally required to protect the lives and improve conditions for Pennhurst residents during and after the pending reduction in population from 1,799 to a Maximum Allowable Census which has now been reduced to 615 persons, thus increasing the cost per person per bed to $35,452 from $23,469+.

It is clear that we can no longer afford the luxury to spend what has to be spent to assure minimum safety and convenience for Pennhurst residents during the length of time required for the County Programs to gear and tool themselves up to support a systematic phased redirection of capital resources into optimum use con-

sistent with the Department's humane commitment to reverse Pennsylvania's mental retardation service system from its institutional base to one based in the communities. It is obvious that the capital investment now required on-site at Pennhurst violates this office's Principles and Policies for Renovation and Construction at State Schools and Hospitals. (Principles & Policies Statement attached) The new renovation cost of $21,803,522 is far greater than the functional worth of Pennhurst's existing buildings after such renovation; in fact it is $2,827,356 in excess of the $18,976,166 estimated as the cost of rebuilding the institution. (Plan C, Master Facilities Plans A, B and C, Bureau of C & M, July, 1971)

The truth of the matter is that while it might be less expensive to construct new buildings at Pennhurst than it would be to renovate existing buildings; both options are prohibitively expensive in comparison with the option for logical dispersal into the community and cannot, therefore, be justified in terms of either an economical 50 year fiscal commitment for the Commonwealth or as being in the best interests of those to be served. (See Act 256 Dispersal Proposal Projection attached)

[3]

Proposed Cost Per Person On-Site Prior to Reduction of Maximum Allowable Census of Existing Resident Housing	$23,469+
Proposed Cost Per Person On-Site After Reduction of Maximum Allowable Census and Required Additional Renovation (Plan B)	$35,452+
Proposed Cost Per Person On-Site After New Construction of Resident Housing (Plan C) . .	$29,284+
Proposed Cost Per Person, Community Dispersal Project .	$21,980+

Fortunately the recent activities of the Department's new Capital Facilities Planning Committee provide us a new, more viable, more economical and potentially more human option for accelerating the Pennhurst dispersal process. It was determined on March 27, 1972, by the Committee that it was realistic to project the transfer of from 560 to 800 Pennhurst residents to Embreeville during fiscal year 1972-73. Subsequently it was further determined by engineering staff from Pennhurst and Southeast Region that approximately $1,519,500 would be required for specific renovations (exclusive of air conditioning) necessary to meet appropriate safety, health, social and program standards for the first 560 persons to be so moved.

The Embreeville Transfer option is of course a compromise. It would be foolish to consider this stop-gap phasing of Pennhurst residents into 12 year old hospital buildings designed to provide custodial care for mental patients as anything but a temporary measure forced upon us by the emergencies of an obsolete, deteriorated and overcrowded State School and Hospital system. To do so would violate OMR Principles and Policies to the same degree that Pennsylvania's existing mental retardation institutions violate these principles and policies. However it is a compromise that could be acceptable and one the Department might implement without losing credibility if it is made clearly subject to the constraints implicit in OMR Principles and Policies and with a guaranteed time limit placed on the continuing use of Embreeville consonant with a rigorous Departmental enforcement of County Program responsibility to develop and establish adequate and appropriate residential and non residential community alternatives to institutionalization for mentally retarded persons and their families. If properly controlled, the use of Embreeville to augment the Act 256 Dispersal Project could provide:

1. immediate relief to Pennhurst residents from the serious safety, health and social hazards endemic in that institution;

2. a savings to the Commonwealth of $17,398,000 currently proposed for further capital investment in an obsolete functionally worthless uneconomical State School and Hospital; and

3. an acceptable temporary transitional phase from old warehousing patterns of institutional care to normalizing accommodations in the community.

4. a total phase-out of Pennhurst during fiscal year 1974-75. (If the Embreeville Option is Exercised, attached)

[4] Best of all, if the use of this transfer option succeeds for Pennhurst and the Southeast Region it can open the door for logical State-wide dispersal and reorientation into the communities of all State School and Hospital residents in excess of the population any given institution can properly care and program for under the constraints imposed by OMR Principles and Policies for Capital Investments In State Schools and Hospitals.

This office, therefore, recommends that the Department exercise its authority to implement the Embreeville Transfer option as rapidly as possible; but only under the following conditions to ensure that:

1. There shall be strict adherence to OMR Principles and Policies for Capital Renovation and Construction;

2. There shall be strict adherence to the National Association for Retarded Children Policy Statement on Mixing of the Mentally Ill and the Mentally Retarded (pages 10 and 11, Policy Statements on Residential Care Adopted by the Board of Directors of the NARC, October, 1968, attached)

3. The mentally retarded residents of Embreeville shall reside in a separate and discrete unit(s), shall be provided with separate and distinct programs and shall be under the direction of a separate

administrative head ultimately responsible to the Commissioner of Mental Retardation through the Southeast Regional Office. He shall have such experience and training as is appropriate to supervise and direct a developmental residential service for mentally retarded persons.

4. The appropriate Base Service Unit shall be notified regarding each person transferred to Embreeville from Pennhurst and there shall be strict adherence to the provisions of 5200 Appendix IV regarding the functions of the Base Service Unit in regard to persons in residence in facilities. The Aftercare Services as defined in Appendix IV shall be provided in collaboration with the individual's family, the Embreeville staff and the person himself when possible.

5. The 5 Southeast County Program Offices shall develop and include as part of their Annual Program Plan and Budget Submission plans for the further dispersal of those persons temporarily placed in residence at Embreeville within a reasonable amount of time.

6. There shall be regional participation in the planning and implementation of the Embreeville Transfer option as defined in OMR Principles and Policies.

[5] Further, pending final acceptance of the foregoing recommendation and conditions, this office herewith requests that all the various available and proposed renovation and/or construction projects for Pennhurst be cancelled with the exception of the following:

$21,079,000 —	Act 256 —	Dispersal Project
$ 387,500 —	Act 256 —	Air Condition Hyperactive Children's Building (this project is retained since the Hyperactive Building is the newest structure on the Pennhurst Campus will undoubtedly be the last to be abandoned. It might be prudent to retain this building in as useable a condition as possible to provide back up placement for 168 persons beyond the projected 1974-75 phaseout date in the event of emergencies or special problems.
$ 50,000 —		Property and Supplies for 1971-72 — Install lift station forced main from dairy complex to sewage disposal (this is required — citation for pollution)
$ 53,000 —		Regional Jobs (These are relatively small emergency repairs required for day to day operations)
		Replace roof and flashing.
		Boys' Vision Unit 11,000
		Girls' Vision Unit 11,000
		Repair Roof, Building G (Dietary) ... 3,000
		Repair build up roof (?) 6,000
		Provide toilet facilities, Penn-Hall Grove 6,000
		Repair Penn-Hall roof 8,000
		Renovate condensate return system, Building 5 8,000
$21,569,500		

It is also recommended should the Embreeville option be implemented, that sufficient capital funds be added to the estimate of $1,519,500 required for renovation at Embreeville to provide air conditioning as indicated to further protect the health and well-being of the transferees.

Approximately one year ago today, on April 19 and 20, 1971, this office's Principles and Policies for Renovation and Construction at State Schools and Hospitals were formulated during an Architectural/Program Review convened by this department in collaboration with the Pennsylvania Association for Retarded Children. Gunnar Dybwad, Professor of Human Development, Florence Heller School, Brandeis University; and George V. Gray, Director, Mental Hygiene Facilities Planning, New York Department of Mental Hygiene provided consultant services during this review at the

Department's request and in keeping with the Administration's new commitment to eliminate existing institutional health, safety, and social hazards as quickly as possible and ultimately to insure for every retarded citizen of the Commonwealth his right to live a life as close as possible to that which is typical for ordinary citizens; in his own home or as close to his own home as can be arranged.

[6]

Today, it seems even more relevant than a year ago to posit:

> "The Pennhurst dilemma is the dilemma of all the State Schools and Hospitals. Pennsylvania is at a turning point in its delivery of services to mentally retarded persons but there is as yet: no official redefinition of the State School and Hospital role; no systematic master-plan to coordinate the development of County Programs with projected plans for the institutions; and no guidelines established to redirect available resources into optimum use consistent with the new emphasis that centers on the community as the mandated program base for all mental retardation services. The enlightened authorization of Act 256 (unique in the nation) for investment of more than $21,000,000 in construction in the communities to reduce the overcrowding at Pennhurst by 900 residents, highlights this dilemma and focuses in on Pennhurst as the pivotal starting point for statewide reversal of the traditional institutional role." (Mental Retardation Summary Report State Schools and Hospitals, Architectural/Program Review — 4/19/71-4/20/71.)

OFFICE OF MENTAL RETARDATION — PRINCIPLES AND POLICIES: CAPITAL RENOVATION AND CONSTRUCTION INVESTMENTS

I

Principle:

"The mentally retarded person has a right to live with his own family or with foster parents; to participate in all aspects of community life and to be provided with appropriate leisure time activities. If care in an institution becomes necessary, it should be in surroundings and under circumstances as close to normal living as possible." (Declaration of General and Special Rights of the Mentally Retarded: International League of Societies for the Mentally Handicapped.)

Policy:

No further capital funds shall be invested in new construction on old isolated State School and Hospital sites unless it is verified by professional architectural/engineering and program assessment, that this additional 50-year investment in the life expectancy of the institution is an economical commitment for the Commonwealth; will not encourage unnecessary and prolonged institutionalization, and does not deprive mentally retarded citizens of their right to be served in their own communities.

II

Principle:

"The primary purpose of a residential facility is to protect and nurture the dignity, health and development of each individual requiring twenty-four hour programming services. Inherent to this commitment is the responsibility to provide those experiences that will enable the individual to: (1) develop

his physical, intellectual, social, and emotional capacities to the fullest extent; (2) live in an environment that is conducive to personal dignity while in a residential setting; and (3) continue development of those skills, habits, and attitudes essential to adaptation in contemporary society." (Standards for Residential Facilities for the Mentally Retarded: Joint Commission on Accreditation of Hospitals; Accreditation Council for Facilities for the Mentallyi Retarded.)

Policy:

A professional architectural/engineering and program assessment shall be made of the structural and functional capabilities and requirements of all institutional structures requiring renovation and a determination reached regarding whether or not the proposed expenditure is economical prior to any decision to proceed with said renovation. If the functional worth of the building, after being renovated, is less than the money to be spent in order to do this renovation, the proposed renovation is uneconomical. A maximum allowable census shall then be ascertained for each State School and Hospital based on the reality of each institution's structural and functional capabilities to house and program for its residents appropriately, safely, and economically.

III

Principle:

"The facility should be located within, and conveniently accessible to the population served, so as to have access to necessary generic community services. The facility should not be isolated from society or community by factors such as: difficulty of access due to distance or lack of public transportation; architectural features; socio-cultural or psychological

features; rules, regulations, customs, and habits." (Standards for Residential Facilities for the Mentally Retarded; JCAH.)

Policy:

All future capital investments in facilities to house State School and Hospital residence in excess of the population any given institution can properly care and program for under the constraints implicit in policies I and II above shall be: dispersed into the communities; be under the direction of the County Mental Health/Mental Retardation Program, and shall be small, differentiated, homelike living arrangements in accord with the principles of normalization and in keeping with the Department's commitment to revise the State's mental retardation service system from its institutional base to one based in the community.

IV

Principle:

"The local authorities of each county . . . shall establish a county mental health and mental retardation program for the prevention of mental disability and for the diagnosis, treatment, care, rehabilitation or detention of the mentally disabled. . . . (Mental Helath/Mental Retardation Act of 1966, Article III, Section 301 [a]).

Policy:

The role of each State School and Hospital shall be redefined as follows in keeping with the foregoing principles and policies: A state operated residential service which is only part of residential services which are part of a continuum of community services which the County Mental Helath/Mental Retardation Program is mandated to develop, direct, and deliver in associated coordination for mentally retarded persons and their families.

V

Principle:

"The Department shall have power, and its duty shall be . . . To establish and maintain working relationships with other government bodies and public and private agencies, institutions and organizations so as to assure maximum utilization of services and facilities which each such government body and public and private agency, institution, and organization may have, which may be of benefit to the mentally disabled." (MH/MR Act of 1966, Article II, Section 201 [5].

Policy:

All relevant governmental bodies and public and private agencies, institutions and organizations shall participate in planning, review and final decision making for all future capital renovation and/or construction projects proposed either for institutional sites or for dispersal into the community: including but not limited to County Administrators, Consumers, Consumer Advocate Groups, Regional.

Pennhurst — Current Maximum Allowable Census and Required Renovation Cost

(DPW: Medical Service Office Architectural Survey — December, 1971, and Bureau of C & M, Plan B, Master Facilities Survey Plans A, B & C, Pennhurst State School & Hospital July 1971)

Building	Rated Capacity	Resident Housing Required Renovation Cost
I	64	1,841,000
II	64	1,663,200
III	96	2,359,600
IV	60	3,162,760
V	23	314,160
Penn Hall	40	898,380
Continuing Care	32	1,142,400
M	28	1,123,200
Q	16	608,220
Hospital	24	306,900
New Building	168	314,160
	615	13,733,980

(All other buildings are considered unsuitable for continued occupancy. Under no circumstances, regardless of further investment, the new building cannot be redesigned into compliance with Federal skilled nursing home requirements.)

If the Embreeville Option is Exercised:

Pennhurst Resident Population, October, 1971 — 1,799
Pennhurst Reduction Projects to June 30, 1972 (in process)

Purchase of Community Nursing Care	100
1971-72 Special Living Arrangement Placements	200
Initial Transfers to Embreeville	20
Transfers to EPPI (emotionally disturbed)	16
1971-72 TOTAL REDUCTION	336

Projected Resident Population, June 30, 1972 — 1,463

Pennhurst Reduction Projects to June 30, 1973

Transfers, to Embreeville	600
1972-73 Special Living Arrangement Placements	200
New Southeastern State School & Hospital	150
1972-73 TOTAL REDUCTION	950

Projected Resident Population, June 30, 1973 — 513, or 102 less than the maximum allowable census.

Pennhurst Reduction Projects to June 30, 1975
Act 256, Dispersal Project — 959

Projected Resident Population — June 30, 1975 — minus 446

By 1974-75, it should be possible to completely phase out Pennhurst and have 446 community placements available either to reduce the Pennhurst waiting list or for further dispersal of those temporarily placed in residence at Embreeville.

PARC Ex. 26

PRESS CONFERENCE
MAIN CAPITOL BUILDING, GOVERNOR'S PRESS ROOM
THURSDAY, DECEMBER 14, 1972, 10:00 A.M.

Participants: Mrs. Helene Wohlgemuth, Secretary of Public Welfare
Mrs. Patricia Clapp, President, PARC

Questions from the press and answers from Secretary Wohlgemuth, assisted by Mrs. Clapp and Edward Goldman, Commissioner of Mental Retardation. Recorded and reproduced by Richard Parker.

Q. What is being done to prevent the group home from turning into an interim care facility?
A. An adequate level of care is being provided; personnel are being trained; supervision from the Base Service Unit is required; a monitoring system is functioning; arrangements with PARC through the Fellowship Plan so children are not lost in the system.
Q. How much will it cost to eliminate peonage?
A. This is being done in phases, but $1.5 million is in the budget.
Q. Where will you get the money if the Legislature refuses to give it to you?
A. I don't know, but it will be a real struggle.
*Q. If we are leading the nation in group homes, then cannot the money be used better somewhere else?
A. We are at a point in Pennsylvania with a program that is based in institutions. The cost of maintaining huge plants eats up dollars that should be used to care for people. We must start transferring institutional budget money into the community program. It is not good business to maintain these old warehouses.

*Q. Is it cheaper to house 1,000 mentally retarded people in 50 group homes than in one institution?
A. Absolutely — the institutional cost is four times as high as the group home. The cost in the institution ranges from $17.00 per day, per person to $35.00 per day. In the community home, the cost is approximately $8.00 per person, per day. This represents a very definite savings.
Q. Why then do we need the $12 million Deficiency Appropriation?
A. First, to reverse the processes of institutionalization requires money and time. Secondly, the recruitment and training of personnel. Then, thirdly, there is the cost of a monitoring system so we do not lose track of people.
*Q. If we do not get the $12 million, will be abandon the community home plan?
A. Positively not. We are committed to it and we owe it to the retarded.
*Q. Are you saying that all Pennsylvania institutions for the mentally retarded could be closed?
A. With the appropriate arrangement facilities, yes.
Q. How many people are being warehoused in state institutions?
A. 11,000 including those in the interim care facilities, with 5,000 on waiting lists for the institutions.
Q. What do the people do in a community residence?
A. Their lives parallel closely the lives of people in other homes on the street. They are encouraged to socialize. The purpose of the home is to normalize the life of the retarded. Life in an institutional setting dulls ones potential. There are approximately eight to twelve persons in a community home. We don't want to start building small institutions.
*Q. Won't the Legislature look at this $12 million request as welfare?

A. They may try to hide it under welfare, but the Legislature knows it is for the mentally retarded.
Q. How many staff members are required to a community home?
A. A set of full time house parents and a set of part time house parents who provide relief on the weekends. Also part time college and high school students who volunteer their services.
Q. In thirty communities where the homes are established, what is the reaction of the community?
A. Apprehension in the beginning, but once it is established, the people in the neighborhood get interested and often participate.
*Q. Will we see the day when all institutions in Pennsylvania will be closed?
A. Yes, we are going to close them all.
Q. Isn't it true the Right to Education is a financial responsibility of the Department of Education?
A. Yes, except for the children who are institutionalized.
*Q. Will there still be a need for the institution for the severely and profoundly retarded?
A. We must bring the severely retarded back to their own communities. We must try to place them in perhaps university hospitals or in other places where they will receive sophisticated professional care.

*Take special note of these questions.

COMMONWEALTH
of PENNSYLVANIA

The Governor's Review — 1975

WELFARE AND MENTAL HEALTH

[39] The mental health team, a total of 15 members, was responsible for surveying the operations of the Department of Public Welfare with particular emphasis given to the state's mental health and mental retardation institutions. In an effort to gain as much insight as possible, groups of two or three individuals spent the first five weeks of the study period visiting the various institutions and the department's four regional offices. Team members spent as much as two weeks at a single institution, reviewing its operations in detail. Later, they visited other facilities for one to three days. In all, 20 of the state's 31 mental institutions were covered. In order to achieve as broad a view as possible of the organization, operation and administration of individual facilities, team members also spent some evenings and weekends at the institutions and even participated in programs with patients/residents.

Visits were made to community-level mental health facilities throughout the state to gain a first-hand impression of possible alternatives to institutional care. In addition, operations of the County Boards of Assistance were reviewed. Following the field work, interviews were held with department personnel in Harrisburg to identify over-all objectives, operating methods and problem areas.

The department has been mandated through the Mental Health and Mental Retardation (MH/MR) Act of

1966 to develop an overall system of care which will make greater use of community-level mental health centers and thus decrease the number of persons committed to institutions. Implementaion of this objective has been very slow. Apparently, there are a number of factors contributing to this lack of effective action. A prime requirement — still unfulfilled — is the development of a comprehensive, long-range plan with specific objectives. Interference from unions, special advocacy groups and local civic and political organizations has been another impeding factor. Strong, determined leadership is needed to move the department ahead to carry out its objectives despite existing opposition.

Although the deprtment lacks a comprehensive program, a tremendous amount of planning is done. However, it is fragmentary, uncoordinated and, for the most part, unimplemented. For example, regionalization of the department's administrative functions has been implemented in part, but there has been no delineation of responsibilities or appropriate delegation of authority. As a result, there is confusion, inadequate accountability, responsibility gaps and a duplication of work between the central office and the regions. All contribute to reduced effectiveness and higher costs. A number of crganizational and operational problems also exist within the County Boards of Assistance.

A recommendation has been submitted which mandates a comprehensive plan oriented toward the concurrent build-up of community MH/MR programs, together with a consolidation of institutions into more cost-effective operations as balanced components of a good complete, overall mental health care system. The depersonalization of individuals in antiquated and inappropriate buildings at the institutions is very apparent. The observed results of moving these people to community-sponsored facilities mandate the aggressive development of more of these programs under county sponsorship. Individual recommendations to support

and augment the comprehensive plan relate to the closing or phasing down of institutions, the provision of monetary incentives to the private sector, the movement of state employees to community programs and the allocation of an appropriate funding stream for accomplishing all this. It is important that the state realize not all groups can be satisfied, and that some must be temporarily inconvenienced for the long-term good of the majority.

A new organizational structure for Department of Public Welfare has been proposed which will strengthen the regionalization concept, and make it a more effective system for managing the state's institutions, programs and functions.

Several recommendations deal with methods to improve the functions of the County Boards of Assistance. These include computerization of files and assigning direct control of all activities to the regional commissioners, Income Maintenance. In addition, it is recommended that the number of board offices in the state be reduced.

In evaluating these recommendations, it is important that those responsible for implementation focus more on the broad, overall methodologies presented, rather than on some of the details included in the write-ups.

As a result of the team's involvement with the mental health program, some of the recommendations presented may go beyond the clear limits of management and administration and cross into the gray area of program and mental health science. This has not been done in an accidental or haphazard manner, but with close coordination and counsel from knowledgeable persons within the department.

Despite the problems which were identified, the team members were impressed by the professionalism and dedication of the employees they contacted in the Department of Public Welfare. In many cases, outside

pressures have prevented them from fully realizing
[0] wortwhile goals in regard to the state's mental health and mental retardation institutions. Concentrated planning, effective guidance and dynamic leadership are needed to enable the department to overcome these pressures.

* * *

STATE MENTAL HEALTH AND MENTAL RETARDATION INSTITUTIONS

[52] The Department of Public Welfare operates 20 state hospitals for the mentally ill and 11 schools and hospitals for the mentally retarded. The Mental Health/Mental Retardation (MH/MR) budget for fiscal 1975 was $405-million. Of this amount, $287-million was state funds. During the past 10 years, institutional populations have decreased from about 48,000 to 26,000. This is in line with the trend toward deinstitutionalization initiated by the 1966 Mental Health/Mental Retardation Act. It authorized establishment of a wide range of services for the mentally disabled at the community level. Staff levels, however, have increased during the period from 20,400 to 25,500.

RECOMMENDATIONS

147. Develop a comprehensive MH/MR plan which specifies facility consolidations within the service framework mandated by the MH/MR Act.

Under the MH/MR Act of 1966, the state is committed to developing — in cooperation with its communities — a mental health and mental retardation care system which provides a total spectrum of services. However, there have been many delays in the actual realization of this system. A major roadblock has been the disproportionate flow or human and dollar resources into the institutional component of available service facilities. As an example, the fiscal 1975 appropriation provided $403-

million for MH/MR institutions while furnishing only $83-million for county-operated programs and services.

Proposed Approach: The department secretary should assign top priority to the development of a concise plan to specify cost effective consolidation and utilization of state-operated institutions. It should be consistent with the framework established by the MH/MR Act of 1966 and contribute to the state's program to provide a total spectrum of adequate services at an affordable price. The proposed plan should include the following objectives:

- Consolidate MH/MR operations with the best physical and program resources.
- Achieve full utilization of necessary institutions.
- Phase out and dispose of obsolete and marginal facilities promptly.
- Develop a common funding stream for state and community programs and apply a substantial portion of the resources saved in institutional consolidations to the development of community programs.
- Budget to meet long-range program objectives based on a total project life cycle.
- Develop a program to facilitate transfer of trained institutional personnel into county programs.
- Establish an appropriate statewide balance between the geographic distribution of persons requiring services and the programs, facilities and services available to meet those needs.

A component plan should be developed for each of the department's four administrative regions. The components should define all the necessary decisions to be made and the steps to be taken in accomplishing specific regional objectives. Major benefits will be realized in

terms of improved care and treatment for those individuals who require MH/MR services. Development of alternative types and levels of service and care at the community level should substantially reduce the requirements for long-term confinements and, as a result, could lower the institutional population dramatically. Some 18 of the recommendations which follow represent integral parts of the proposed comprehensive program. Specific savings have been included with the individual recommendations. The overall amount is estimated at more than $30-million annually with a one-time benefit of almost $90-million.

Implementation Strategy: The successful implementation of a comprehensive MH/MR system will depend on the development of a master plan. It must clearly define feasible consolidations, tasks to be performed and schedules to be met. Accurate cost estimates and budgets must also be provided. The secretary, Department of Public Welfare, should have a master plan completed within three months.

* * *

[55] **155. Close all of the obsolete and unneeded MH/MR institutions.**

Many of the state's MH/MR institutions were built more than 50 years ago when the philosophy of patient care was different from what it is today. In some cases, residence buildings will require extensive and costly changes to meet standards established by the Life Safety Code. Even with renovations, the majority of the structures will still not be suited to modern rehabilitative programs. However, a continuing trend toward deinstitutionalization and development of more community programs have caused underutilization of facilities in more modern institutions. While the Department of Public Welfare has taken some steps to phase out obso-

lete institutions in favor of improved utilization of newer ones, various pressures from union and community groups have halted progress toward this objective.

Proposed Approach: A comprehensive plan to redistribute MH/MR patients has been suggested in another recommendation. As part of this program, some of the institutions which would require extensive renovation should be closed. This should be done under a coordinated approach as other institutional and community facilities are made available. In addition to the three institutions identified for closing in other proposals, at least three others should be closed. Possibilities might be Dixmont, Cresson and Hamburg.

Implementation would provide an annual saving of approximately $6-million in state and $6.5-million in federal funds. A further benefit would be improved staffing ratios in the remaining institutions through reassignments of professional personnel. This will enhance the department's overall ability to qualify for federal medical assistance payments, thereby increasing the potential income to the state.

Implementation Strategy: The deputy secretaries, Mental Health and Mental Retardation, should develop a program to identify and phrase out obsolete and unneeded facilities in accordance with the comprehensive regional facility plans. An aggressive approach to developing community programs and renovating usable residence buildings could bring about accomplishment of this objective within three years.

* * *

[62] **172. Close and demolish obsolete buildings at state MH/MR institutions.**

Many state institutions were built more than 40 years ago when the philosophy of patient care was significantly different. As a result, the buildings are both physically old and unsuitable for today's rehabilitation programs. In order to qualify for federal medical assistance grants, state institutions must conform to certain safety and staffing standards. To bring all institutional buildings, including many that are obsolete into conformance with these regulations would require an expenditure of about $60-million. Because patient populations are on the decline, a number of newer buildings are underutilized. Many of these can qualify for federal medical assistance grants.

Proposed Approach: The department should redistribute patients to appropriate institutional and community facilities in order to close buildings which will not be required within a three-year-period. This will make older institutions more manageable in terms of physical plant operations and resident populations. Staffing can then be adjusted to optimum levels. In addition, moving patients to more modern facilities will provide improved surroundings and increase the state's participation in federal assistance grants. Also, there is an estimated potential cost avoidance of $10-million through eliminating the need to renovate obsolete buildings. If a total of 90 buildings were closed, there would be a one-time cost of $4.5 million to demolish them.

Implementation Strategy: The department secretary should undertake the following activities:

- Continue the freeze on implementing federal renovation requirements.
- Review all residence facilities to identify those which should continue in operation and those which should be abandoned.

- Begin repairs and construction work on habitable buildings as soon as possible.
- Encourage community-level program development.
- Transfer residents in obsolete facilities to more appropriate locations.
- Ensure that all new facilities meet federal government requirements.

Overall, implementation of this proposal should require about two years to complete.

* * *

PARC Ex. 33

MONTGOMERY COUNTY • COURT HOUSE • NORRISTOWN, PENNSYLVANIA 19404

MENTAL HEALTH
MENTAL RETARDATION
DRUG AND ALCOHOL
PROGRAMS

HERMANN A. ROETHER, Ph.D., ADMINISTRATOR

February 28, 1977

TO: Russell G. Rice, Jr.
MR Commissioner, S.E. Region

FROM: Edward R. Manning

REGARDING: Need Assessment and Budget Projections on the Deinstitutionalization of Montgomery County Persons residing at Pennhurst Center

The Montgomery County population at Pennhurst Center as of 2/25/77 is 130.

The projected over all cost to the community program to deinstitutionalize the above population is $1,911,406.*

In summary, this is broken out as follows: (see attached pages)

RESIDENTIAL COSTS	
(based on 100% Pennhurst occupancy)	$1,393,886
DAY PROGRAMS	
(training and vocational)	455,520
SUPPORT PROGRAMS	
(additional impact on FRS)	52,000
(additional impact on out patient)	10,000
TOTAL	$1,911,406*

Following is a list of tables attached to show more specific information:

TABLE I

Montgomery County clients at Pennhurst Center Breakdown according to type of residential program

needed together with age, functional level and indications of multiple handicaps. (Names can be furnished immediately on request).

TABLE II

Breakdown of number and types of projects needed to serve the population, together with total costs, annual individual costs, and per diem rates.

TABLE III

Budget breakouts for each individual project.

TABLE IV

Cost breakout for needed programs.

Please note that all projections are based on programmatic information given by the Social Services Department of Pennhurst Center.

ERM/maf

Attachments *130 clients for 1 year at Pennhurst = $2,888,730

TABLE I
MONTGOMERY COUNTY CLIENTS
AT PENNHURST CENTER

76 - clients fully amb.
54 - clients multi-handicapped
130 - total clients

BREAKDOWN

76 - fully amb.; no sensory disability
3 - totally deaf
11 - hearing disabilities
10 - totally blind
2 - visually handicapped
9 - totally non-amb. (bed stay)
4 - amb. with assistance
11 - wheelchair
1 - amb. with assistance also hearing & visual handicapped
1 - wheelchair and also totally blind
1 - blind and hearing handicapped
1 - deaf and visual handicap
130 - clients

PENNHURST CENTER (Montgomery County clients)

37 clients need DMU facility
3 clients need Children's Development Home
8 clients need Children's Intensive Behavior Shaping
33 adult clients need Intensive Behavior Shaping
42 clients need long-term shelter
7 clients need short-term shelter
130 clients total

37 clients need DMU facility

Breakdown by Sex	Breakdown by Age	Breakdown Functional Level
25-men	8-teen years	1-mild
12-women	8-20 to 29	13-severe
37-clients	1-30 to 39	23-profound
	12-40 to older	37-clients
	8-age unknown	
	37-clients	

41 clients need Intensive Behavior Shaping Home

Breakdown by Sex	Breakdown by Age	Breakdown Functiona' Level
28-men	8-children	1-moderate
13-women	9-20 to 29	17-severe
41-clients	3-30 to 39	23-profound
	12-40 to older	41-clients
	9-unknown	
	41-clients	

3 clients need Children's Development Home

Breakdown by Sex	Breakdown by Functional Level
3-boys	1-moderate
	2-severe

42 clients need long-term shelter

Breakdown by Sex	Breakdown by Age	Breakdown Functional Level
32-men	7-20 to 29	1-mild
10-women	11-30 to 39	5-moderate
42-clients	16-40 to older	32-severe
	8-age old unknown	4-profound
	42-clients	42-clients

7 clients need short-term shelter

Breakdown by Sex	Breakdown by Age	Breakdown Functional Level
2-men	1-20 to 29	1-without retardation
5-women	4-30 to 39	1-mild
7-clients	2-40 to older	3-moderate
	7-clients	2-severe
		7-clients

TABLE II
ESTIMATED BUDGET FOR COMMUNITY RESIDENTIAL COSTS

Total Cost — $1,393,886.00

Intensive Behavior Shaping.
41 clients (6 homes)

$513,773.00 — total cost for 6 homes
34.33 — daily cost per resident
$12,531.00 — annual cost per resident

Long-term Sheltered
42 clients (5 homes)

$339,747.00 — total cost for 5 homes
22.16 — daily cost per resident
$8,089.00 — annual cost per resident

DMU (apartments)
37 clients (12 apts./3 persons per apt.)

$446,033.00 — total cost for 12 apts.
33.02 — daily cost per resident
$12,054.00 — annual cost per resident

Short-term Adult
7 clients (2 apts.)

$52,242.00 — total cost for 2 apts.
20.45 — daily cost per resident
$7,463.00 — annual cost per resident

Children's Developmental
3 clients (1 apt.)

$42,091.00 — total cost for 1 apt.
38.44 — daily cost per resident
$14,030.00 — annual cost per resident

TABLE IV

Cost Estimate for Day Service
-$18.00 a day for day activity center
-$14.00 a day for workshop
-240 days per year

Intensive Behavior Shaping Clients

-$142,560.00 cost for day activity center for one year serving 33 clients

Long-term Shelter

-$77,760.00 cost for day activity center for one year serving 18 clients

-$80,640.00 cost for workshop for one year for 24 clients

Developmental Maximation Unit

-$120,960.00 cost for day activity center for one year serving 28 clients

-$10,080.00 cost for workshop for one year serving 3 clients

Short-term Shelter

-$23,520.00 cost for workshop for one year serving 7 clients

TOTAL COST — $455,520.00

* * *

A988

PARC Ex. 38

A HISTORY OF PENNHURST 1908-1926

Robert Smilovitz, Ed.D.

Introduction

As you read the following you will, if you disregard dates, discern an almost eerie similarity to our present situation. High costs, few staff, crowded buildings, inadequate facilities, insensitive legislators, confused contradictory labeling, inappropriate placements, delinquents, etc. are all clearly documented. You will also find the etiological base of what we today call peonage, the medical model and institutionalization. In retrospect you can also read between these lines and conclude what you will.

A Brief History of Pennhurst 1908-1926
Compiled from Superintendent Reports*

Robert Smilovitz

1908

"The Institution was first opened for the reception of patients November 23, 1908. Only two buildings were at that time ready for occupancy as Ward Buildings, viz: buildings "T" and "Q". Owing to the pressing need and urgent demand for accommodations for patients, the Institution was opened before it was completed, thus entailing a very much greater operating expense than an Institution complete in all its parts."

" 'Youngest institution of its kind in Pennsylvania' before completion of buildings adapted for the various uses set forth in the Act under which the Institution was created. Incomplete as it was (and still is, for that matter), we yielded to the urgent demand for accommodations for the feebleminded and epileptic, and equipped two buildings as ward buildings."

"Building 'P' at present in use as Administration Building was designed for a Teachers' Building."

"Building 'Q' now used as a Low Grade cottage, was designed for a School Building."

"Building 'R' now used as a School Building was designed for an Industrial Building."

"Building 'F' now used as a Chapel and Amusement Hall, was designed for a dining room."

"The present Engineering Department for Storeroom purposes."

The fact is, that only three of the buildings at present occupied are used in their entirety for the purpose for which they were designed. These are "T", "U" and "V" and a portion of "U" is used as a hospital ward and a portion of "T" as a dispensary."

* * *

[2] "A number of the patients admitted during the first few months were transferred from Institutions for the Insane throughout this section of the State. A large percentage of them did not classify in a special Institution, and it was necessary to return a large proportion of them from time to time."

" 'Q' Building, as already stated, designed as a School Building, is being used as a cottage for low grades. The use to which it is put is as far from the use for which it was designed as opposites could possibly be. Its location, near the Administration Building, is objectionable, as this class of patients is always noisy, and should be kept near the central portion of the Institution.

"R" Building, designed as an Industrial Building, is being used both for this purpose and as a School Building.

Building "P", designed as an Employees' Home, is being used for this purpose, and also temporarily for administrative purposes.

Building "F", our only Assembly Hall and Chapel, was designed as a Dining Room for patients.

The second floors of Buildings "F," 'G" and "N," are all used as quarters for employees. This is a far from satisfactory arrangement, but it is the best we can do under existing conditions." (Where's the committee)

"During the first eighteen months of the Institution's existence there was considerable confusion as to the class of patients to be admitted, as the general public apparently did not understand the meaning of the terms "feeble-minded" and "epileptic." All sorts and classes of cases have been sent-the violently insane, with homicidal and suicidal tendencies; the maniac, with delusions of persecutions; the religious paranoiac, the paretic, with delusions of grandeur; cases of amentia, moral imbeciles, reformatory cases, criminals and so forth. The parents of these cases were content with the belief that sending children to a Special Institution did not place upon them the stigma which would result were the cases sent where they belonged, viz: to the Insane Asylum, the Reformatory and, in some cases, the jail.

Finally, this question, as to the class of cases to be admitted into this, a special institution, designed to handle a specific and definite class of cases, has apparently been settled. In order to arrive at a decision it has been needful for your Board to adopt certain rules and regulations. In the first place, it was necessary to obtain from the proper authorities the opinion that an insane individual is not a proper subject for classification in this institution." (How did you do it?)

* * *

[11] Building "K" Built — "received first inmates October 10, 1911 thus relieving the crowded condition of other buildings." Population increased from 313 (1910) to 466 (1912). Staff remained the same as 1908. (here we go)

"The increased cost of foodstuffs, and nearly all other materials and commodities, is the same serious factor here as everywhere. We are confronted with this condition at every point, and we meet it as a practical question must be met, realizing that cost determines maintenance. However, a proper economy, consistent with efficient administration and the general welfare of the wards of the State, is observed."

"This Institution is operated and maintained as economically as it is possible to conduct it, certain facts considered. The Institution was opened November, 1908. The period from that time to the present, covering the opening and organization, has been marked by the highest prices known in forty years. The effects of this changed condition the Institution has felt and continues to feel very keenly; but we realize that little else can be done than to adjust ourselves to it."

"Whilst our aim and effort is to conduct this Institution in conformity with the Act creating it, only male inmates are accepted. We have carefuly considered this question, and we have reached what we believe, under present conditions, to be a wise conclusion. When it is stated that we have no facilities for keeping the sexes entirely segregated, the reason for male inmates is obvious."

"As Trustees, we are aware how the number of degenerates in this Institution has increased; from what large families they come, as a rule; how rapidly applications for admission are coming in; that the reports are practically the same from other sections of the State. We are aware that this whole subject, in all its seriousness, has forced itself upon the attention of State bodies, medical associations, legislators, Judges of the Courts and other thoughtful persons. Everywhere the increase in the number of the institution classes is regarded as an alarming condition, growing in gravity far more rapidly than our great State is able to provide room and proper care in her numerous institutions. Further proof of this

unfortunate increase is not needed; all men are convinced, and agree that something must be done without delay." (1910)

* * *

(The primary prevailing philosophical thoughts of the past used to justify requests for more buildings and staff)

* * *

Prevailing philosophy

"The number of applications for admission is steadily increasing. We have been able to admit only a small proportion of these applicants, due to our lack of accommodations. For this increase in the number of applications for admission there are many reasons. The subject
[28] of feeble-mindedness has been much more largely discussed and written about during the past few years. Through various agencies, parents, physicians, teachers, courts, etc., have gained a better knowledge of the nature of feeble-mindedness and of the advisability of institutional care of the mental defective, and the public has come to realize that the feeble-minded child is entitled to that kind and degree of training compatible with its capacity. The helpless idiots and feeble-minded women and girls of child-bearing age are notably those for whom there is increasing demand for custodial care. There is no question that the irresponsible feeble-minded person, especially the feeble-minded woman or girl of child-bearing age, at large, is a menace from whom the community has a right to demand protection.

The increase in the number of feeble-minded persons in institutions at the present time and in the number of applications for admission to the Institution is not proof that feeble-mindedness in on the increase in our various communities, but it is rather the evidence that the people of the State are coming to a better under-

standing of the significance of feeble-mindedness and the need of permanent custodial care, not only from the need of the individual himself, but for social and economic reasons.

* * *

In such an Institution as this, where there is the combined care of the feeble-minded and epileptic, a large amount of time and attention is required by this latter type of case.

The tendency in almost all cases of continued epilepsy is for mental deterioration or mental loss to take place. Very few epileptics escape quite free from a certain amount of dullness. A certain percentage of these patients suffer at times from acute and severe mental disturbance, at which time they are much confused and often violent and dangerous. During the past year it became necessary to have a case of epileptic insanity transferred to a hospital for the insane, not only because we did not have the proper facilities for caring for such patients, but we could not subject our other children to the danger.

Where both feeble-minded and epileptic individuals are cared for in a single institution, no matter what degree of mental deterioration the epileptic may have, the arrangement of the Institution should be such as would permit of separating the different classes in different cottages or wards. Epileptics showing little or no mental deficiency should, of course, be separated from the other inmates, whether epileptic or feeble-minded only."

"We do not propose to create or supply faculties absolutely wanting; not to bring all grades of idiocy to the same standard of development and discipline; nor to make them all capable of sustaining credibility all the relations of a social and moral life; but rather to give to dormant faculties the greatest possible development, and to apply these awakened faculties to a useful purpose under the control of an aroused and disciplined will."

"The educational means at our disposal for the training of the feeble-minded child are physical (those addressed to the body) and mental (those addressed more particularly to the intelligence). But we must not lose sight of the fact that the two are not independent of each other. The specific exercises whether physical or mental should have for their direction a skilled teacher, acting in concert with the physician. The kind and amount of educational exercise as well as the kind and amount of industrial work appropriate to the individual case of mental deficiency should be prescribed by the latter.

The physical and mental means cannot be separated but they go hand in hand. In the words of "Seguin" the physiological education of the senses must precede the physical education of the mind.

Feeble-minded children show not only a lack of mental development but they are deficient in bodily development. Physical training is therefore necessary and serviceable for both muscular growth and coordination. The necessity of such training shows the need of a gymnasium properly equipped such as is found in all other institutions for the training of the feeble-minded.

The school and training department have been conducted along the lines described in the past reports. The pupils show great interest in the training work."

"To sum up, the program now possible includes the mental examination of backward school children, the mental clinic, the training clinic, the special class, directed training of individual defectives in country schools, instruction of parents of defective children, after care of special class pupils, special training of teachers in normal schools, census and registration of the feeble-minded, extra institutional supervision of all uncared for defectives who need segregation for institutional care, increased institutional facilities, parole for suitable institutionally trained adult defectives, permanent segregation for those who need segregation, mental

examination of persons accused of crime and all inmates of penal institutions, and long continued segregation of defective delinquents in special institutions."

Post Script

The only constant is change — but what direction does it take?

Robert S. Smilovitz, Ed. D.

PARC Ex. 40

PENNHURST IN PERSPECTIVE: PURPOSE, PROGRAMS, POSSIBILITIES

It is said that he who does not learn from the mistakes of history *will tend* to repeat them. The history of Pennhurst is replete with mistakes. We are committed to their *"amelioration."*

The custodial model with its emphasis on medical care and a dirth of individualized programming is reflected in statements from the recent past (1945); *"Patient"* population of 2,400 and a staff of 275! *"Patients* who are "absolutely hopeless for training." No routine letters; all correspondence addressed to the Superintendent; *"Patients"* forbidden to write letters for one another; no visiting on legal holidays; visiting *only* on Thursdays and Sundays from 9:00 a.m. to 4:00 p.m.; "do not give *"patients"* money when visiting for they are apt to lose it, spend it unwisely, or give it away"; and the ultimate goal is *"parole"* to the community! "Working patients", "female/male colonies", "defectives", overcrowding, deteriorated buildings, involuntary servitude, untrained staff, and on and on . . . . .

Created by an act of the legislature, Pennhurst opened its doors in 1908. It was immediately overcrowded and understaffed and has continued so. Relative to the tenor of their times, Pennhurst pursued the self-fulfilling prophecy of caring for the "hopeless" ones and showcasing the minimal program efforts for high functioning citizens who rarely, if ever, should have even been admitted to the institution.

This intolerable situation of warehousing persisted intact until the early 1960s. Then Federal action was initiated by President John Kennedy. In Pennsylvania, Statewide awareness was reflected in the MH/MR Act of 1966 which attempted to establish parameters of humane care and programming. However, the plight of the institutionalized citizen with retarded behavior was not

brought to public attention until 1968 when the media focused on Pennhurst. Typical reactions were those of shock, outrage and shame at man's inhumanity to his fellow man. The General Assembly passed Act 256 in 1970 which provided eight million dollars for improvement projects and twenty-one million to develop community-based facilities and services for approximately 900 Pennhurst citizens in order to reduce the population.

Officials in the Department of Public Welfare reacted to the public outcry for appropriate facilities and services by noting that "at the present time, there are approximately 1,000 students at Pennhurst living in utter squalor, housed in unsafe, unsanitary buildings, several previously planned for demolition to make room for new student cottages." Several plans were designed to reduce the population in a manner which would result in an increased staff/resident ratio and the vacating of all unsafe buildings. Though the plans are under way, the majority of Pennhurst citizens still live in unsafe, antiquated warehouses.

Yet, beneath the veneer of despair, the tremors of a dynamic, meaningful revolution reverberate throughout the institution and the State!!!

[2] Within purposeful, clarity-oriented management by objective parameters, Pennhurst is developing a behavioral programming approach which says every — yes, every citizen with retarded behavior can learn. Every citizen is entitled to rights implicit in the Declaration of Human Rights for the Mentally Retarded. No matter how severe the handicapping situation may be, every avenue is explored in developing constructive and positive approaches for the enhancement and betterment of self-dignity; the continuing development of full potential; and the development of a full productive life.

Through close cooperation with families, community resources, institutions of higher learning, and others, we establish both long and short term goals of com-

munity placement (not parole!). Through research, we engage in a constant search for meaningful, relevant, functional knowledge. Through data-based programming, we focus on the individual where he is and move sequentially and patiently through his own developmental hierarchy from one stage of treatment and development to other more complex stages.

The present Pennhurst model (within the material realities we are confronted with) is a heuristic one. The functioning Unit System is instructive for those who still pursue the authoritarian-hierarchical model. The three-stage workshop with an average weekly payroll of over one thousand dollars combined with a realistic scrip economy obliterates peonage and enhances the dignity of work. Functional on-ward behavioral inservice training liberates child care workers from custodial chains and cloaks them with programming skills. Multidisciplinary efforts focus on an individual program for every citizen — a program with definitive short and long term goals and procedures and strategies to achieve them. Simulated on-grounds community orientation programs ease the transition into the main stream community. Advocacy programs; sexuality education; mobility instruction; unique stimulus enriched environments; a communication center for the deaf; extensive volunteer resource efforts; over three hundred recent successful community placements; foster grandparents; data-based school programs; modular homes; and the list goes on.

The sum total of the differences between where Pennhurst was, presently is, and soon will be is immense. It is the difference between "hopeless ones" and all can learn. It is the difference between a "defective patient" and a citizen with retarded behavior. It is the difference between "seclusion" and "exclusion and contingency management and meaningful participation of all. It is the difference between "warehousing items" and providing homelike settings for individual human beings.

In a word, it is the difference between the inhumane and the humane. It is the difference between the Pennhurst of old and the Pennhurst of today.

FOR YOUR INFORMATION

Please write or call my office, Dr. Robert Smilovitz, 948-3500, ext. 268, for a description of any of the aforementioned programs; copies.

PARC Ex. 45

Philosophy, Purpose, Goals, and Objectives

Philosophy

The citizens committed to and residing at Pennhurst State School and Hospital exhibit a limited repertoire of effective and acceptable behaviors. Each individual's performance deficit had become apparent during his or her developmental years; it manifested as inadequacy in mental functioning; and it was associated with impairment in adaptive behavior. The "retardation" was a matter of *degree*, not of *kind*.

The staff at Pennhurst views the term "mental retardation" as a *description* (not a *cause*) of specific lower levels of mental functioning and non-adaptive behavior. Such descriptions of behavior can only arise from observation, measurement, and comparison of performances for a significantly large group of persons sharing the characteristic of "some chronological age". Scores within the group would vary widely, however the performances of a few persons would be judged as "subaverage" or as "retarded".

Causes of retardation are of interest to the staff, but primarily for purposes of preventing, future occurrences of retardation. However, knowing the probable cause of any one individual's retarded behavior does not, in itself, give specific direction to the practitioner (e.g., aide, teacher, therapist). For all persons, the development of any specified performance first requires the acquisition of certain pre-requisite skills. Such is true regardless whether or not the learner is suffering the effects of genetic errors, disease, bio-chemical conditions, or even retardation due to environmental educational or economic disadvantages.

Effects incurred, to close noted immediately above, are generally irreversible; however, the optimal levels of performance for an individual are not necessarily pre-determined by these effects. Consequently at Pennhurst,

the focus is not on the *retarded person* but rather is on the citizen with *retarded behavior*.

The men, women, boys, and girls, who reside at Pennhurst are citizens! They possess human, legal and social rights. As much as is possible, they are to be treated like any other ordinary persons of the same age. Their similarity to normal persons is to be emphasized and their deviant aspects, diminished. If institutionalization does become necessary, the commitment is to be perceived as *temporary;* a return to the community should be arranged just as soon as resources permit.

The statements above reflect the prevailing philosophy at Pennhurst and give rise to delineating the purpose, goals, and objectives of the facility.

Purpose

Pennhurst State School and Hospital exists to provide an environment designed to facilitate all aspects of growth and development of each handicapped citizen temporarily committed to its care so that this individual may live his life with as much dignity, happiness, independence, and usefulness as is inherent in him, both while he is living at the institution and when community resources are adequate to permit his return.

The purpose of the facility, as stated above, implies goals, some of which relate directly to the residents and others which extend beyond the institution, yet still indirectly affect the residents at Pennhurst. Quality care (e.g. health, safety, comfort) must be guaranteed at all times. Appropriate programming must be assured each and every resident. Thirdly, it is readily apparent that Pennhurst must play a significant role in the continuously developing state comprehensive program of providing a wide range of facilities and services for citizens with retarded behavior. Fourth, the facility must establish and maintain productive relationship with parents, families, community representatives, and institutions of higher learning to generate the resources so critically

needed to fulfill the current mission of the institution. Research activity, particularly as relevant to the evaluation of program strategies and tactics, is a noteworthy responsibility. Another focus is the training of institutional staff in recently formulated basic care and programming techniques; this training should be extended to staff of community-based residences and activity centers as well. Also indicated is the continuing development of a public relations and information dissemination system. Interestingly, all of the goals appearing above do relate to the protection and exercise of the human, legal, and social rights possessed by the citizens residing at Pennhurst.

Objectives

Pennhurst is resident-oriented. The Superintendent, Division Chiefs, Department Heads, and other supervisory personnel do prepare work plans in conjunction with the accountability system utilized at Pennhurst which is "Management by Objective". Objectives vary markedly in scope, nature, resources required, duration until fulfillment, etc. Yet each and every objective, so stated, must be consistent with the prevailing goals, purpose, and philosophy of the facility. For example, given the necessary resources: a) vacate ward L-3, an unsafe, warehouse-like living area by *(Date)*, b) reduce census on ward MVU by *(Date)* to comply with recommendations of Regional Standards and Licensing; c) provide personalized clothing for all citizens residing in Program Unit I by *(Date)*; and d) assure all child care aides have been trained and approved to administer medications by *(Date)*. It should be noted also that all objectives are to be as consistent with the "Normalization Principle" as is possible.

C. Duane Youngberg, Ed.D.
Superintendent

Reissued January, 1975

A1003

PARC Ex. 48

PENNHURST SURVEY RESULTS:

TABLE 1: ETHNICITY

	%
WHITE	75.8
BLACK	21.2
HISPANIC	3.0

TABLE 2: AGE

AGE	%
0-15	4.0
16-20	10.1
21-34	40.4
35 or older	45.5

MEAN	25.775	STD ERR	1.349	MEDIAN	32.330
MODE	30.413	SID DEV	13.420	VARIANCE	180.094

TABLE 3: AGE AT ENTRY

AGE	%
4	3.0
5	1.0
6	8.1
7	6.1
8	6.1
9	7.1
10	6.1
11	8.1
12	5.1
13	4.0
14	4.0
15	7.1
16	5.1
17	4.0
18	2.0
19	2.0
20	1.0

TABLE 3: AGE AT ENTRY (Continued)

AGE	%
21	4.0
22	2.0
23	2.0
24	2.0
25	2.0
31	2.0
36	1.0
37	2.0
38	1.0
39	2.0
TOTAL	100.0

MEAN	14.556	STD ERR	.837	MEDIAN	12.400
MINIMUM	4.000	MAXIMUM	39.000		

TABLE 4: YEARS AT PENNHURST

YEARS IN	PERCENT	CUMULATIVE PERCENT	
1	2.0	2.0	
2	4.0	6.1	
3	1.0	7.1	
4	8.1	15.2	
5	2.0	17.2	
7	2.0	19.2	
8	2.0	21.2	
9	2.0	23.2	
10	1.0	24.2	25%—in 10 or fewer years
11	3.0	27.3	
12	4.0	31.3	
13	3.0	34.3	
14	2.0	36.4	
15	2.0	38.4	
16	1.0	39.4	
17	1.0	40.4	

TABLE 4: YEARS AT PENNHURST (Continued)

YEARS IN	PERCENT	CUMULATIVE PERCENT	
18	1.0	41.4	
19	3.0	44.4	
20	2.0	46.5	
21	3.0	49.5	50%—In more than 21 years
22	2.0	51.5	
24	5.1	56.6	
25	3.0	59.6	
26	3.0	62.6	
27	5.1	67.7	
28	4.0	71.7	
29	2.0	73.7	
30	1.0	74.7	25%—In 31 or more years
31	4.0	78.8	
32	1.0	79.8	
34	1.0	80.8	
35	4.0	84.8	
36	2.0	86.9	
37	5.1	91.9	
39	2.0	93.9	
42	1.0	94.9	
43	1.0	96.0	
46	1.0	97.0	
55	1.0	98.0	
57	1.0	99.0	
61	1.0	100.0	
TOTAL	100.0	100.0	

TABLE 5: MOST RECENT MR CLASSIFICATION (IQ)

	%
NONMR	3.0
MILD	9.1
MODERATE	14.1
SEVERE	26.3
PROFOUND	47.5

TABLE 6: MOST RECENT MR CLASSIFICATION (AB)

	%
NONMR	1.0
MILD	10.1
MODERATE	15.2
SEVERE	31.3
PROFOUND	42.4

TABLE 7: EPILEPTIC

	%
NOT EPILEPTIC	72.7
EPILEPTIC	27.3

TABLE 8: CEREBRAL PALSY

	%
NOT CEREBRAL PALSY	78.8
CEREBRAL PALSY	21.2

TABLE 9: BLIND

	%
NOT BLIND	86.9
BLIND	13.1

TABLE 10: DEAF

	%
NOT DEAF	99.0
DEAF	1.0

TABLE 11: MOBILITY

	%
MOBILE	73.5
DEVICE ASSISTED	19.4
NON AMBULATORY	7.1

TABLE 12: COMMUNICATION

	%
VERBAL	72.2
GESTURES	15.5
NO COMMUNICATIONS	12.4

TABLE 13: FAMILY CONTACT

	%
CONTACT	56.7
NO CONTACT	43.3

TABLE 14: NUMBER OF PSYCHOLOGICAL EVALUATION REPORTS

NUMBER	%
0.	1.0
1.	8.1
2.	12.1
3.	15.2
4.	26.3
5.	18.2
6.	10.1
7.	1.0
8.	4.0
9.	4.0

MEAN 4.101 STD ERR .198 MEDIAN 4.019

TABLE 14B: NUMBER OF PSYCHOLOGICAL EVALUATION REPORTS PER YEAR

MEAN .289 MEDIAN .203

TABLE 15: NUMBER OF VOCATIONAL ADJUSTMENT SERVICE REPORTS

NUMBER	%
0.	68.4
1.	3.1
2.	7.1
3.	4.1
4.	6.1
5.	6.1
6.	2.0
7.	1.0
8.	2.0

MEAN 1.204 STD ERR .210 MEDIAN .231

TABLE 15B: NUMBER OF VOCATIONAL ADJUSTMENT SERVICE REPORTS PER YEAR

MEAN .090 MEDIAN .000

TABLE 16: NUMBER OF AUDIOLOGICAL SPEECH/HEARING REPORTS

NUMBER	%
0.	4.1
1.	14.4
2.	20.6
3.	16.5
4.	20.6
5.	6.2
6.	9.3
7.	4.1
8.	2.1
9.	2.1

MEAN 3.381 STD ERR .210 MEDIAN 3.15

TABLE 16B: NUMBER OF AUDIOLOGICAL SPEECH/HEARING REPORTS PER YEAR

MEAN .289 MEDIAN .16

TABLE 17: NUMBER OF OCCUPATIONAL THERAPY EVALUATION REPORTS

NUMBER	%
0.	47.5
1.	19.2
2.	5.1
3.	7.1
5.	1.0
6.	1.0
7.	3.0
8.	1.0
9.	6.1
10.	2.0
11.	2.0
12.	1.0
13.	1.0
15.	1.0
16.	1.0
24.	1.0

MEAN 2.687 STD ERR .449 MEDIAN .632

TABLE 17B: NUMBER OF OCCUPATIONAL THERAPY EVALUATION REPORTS PER YEAR

MEAN .316 MEDIAN .036

TABLE 18: NUMBER OF PROGRAM REVIEWS

NUMBER	%
0.	5.1
1.	7.1
2.	19.2
3.	23.2
4.	14.1
5.	11.1
6.	5.1
7.	4.0
8.	3.0
9. +	8.1

MEAN 3.828 STD ERR .239 MEDIAN 3.304

TABLE 18B: NUMBER OF PROGRAM REVIEWS PER YEAR

MEAN .367 MEDIAN .162

TABLE 19: PRESENCE OF A PROGRAM REVIEW AFTER JANUARY 1976

	%
PRESENT	75.8
ABSENT	24.2

TABLE 20: YEAR OF OLDEST VINELAND (SUBSET OF 48 CLIENTS)

YEAR	%
1940	2.1
1946	2.1
1948	2.1
1949	2.1
1950	6.3
1951	8.3
1952	8.3
1953	6.3
1954	2.1
1955	4.2
1956	2.1
1957	4.2
1958	6.3
1960	2.1
1961	2.1
1963	4.2
1964	2.1
1965	2.1
1966	4.2
1968	10.4
1969	2.1
1971	10.4
1972	2.1

TABLE 20B: SOCIAL QUOTIENT SCORE BASED ON OLDEST VINELAND

SCORE	%
10.	4.2
13.	2.1
14.	4.2
17.	2.1
18.	2.1
19.	2.1
20.	33.3
22.	2.1
23.	4.2
24.	2.1
27.	4.2
30.	4.2
32.	2.1
33.	4.2
34.	2.1
35.	2.1
36.	6.3
42.	2.1
44.	4.2
46.	2.1
49.	2.1
53.	2.1
61.	2.1
70.	2.1

MEAN 27.604 STD ERR 1.882 MEDIAN 20.500

TABLE 21: YEAR OF NEWEST VINELAND (SUBSET OF 48 CLIENTS)

YEAR	%
1953	2.1
1956	2.1
1959	2.1
1966	4.2

TABLE 21: YEAR OF NEWEST VINELAND (SUBSET OF 48 CLIENTS) (Continued)

YEAR	%
1969	4.2
1970	2.1
1971	16.7
1972	14.6
1973	10.4
1974	18.8
1975	12.5
1976	10.4

TABLE 21B: SOCIAL QUOTIENT SCORE BASED ON NEWEST VINELAND

SCORE	%
7.	2.1
8.	2.1
10.	6.3
11.	4.2
12.	2.1
13.	6.3
14.	2.1
15.	4.2
16.	2.1
17.	6.3
18.	2.1
19.	2.1
20.	35.4
21.	2.1
22.	4.2
24.	2.1
30.	6.3
35.	2.1
43.	2.1
49.	2.1
51.	2.1

MEAN 20.063 STD ERR 1.332 MEDIAN 19.735

TABLE 22: SOCIAL QUOTIENT SCORE CHANGE (NEWEST MINUS OLDEST)

DIFFERENCE IN SCORE	%
−50.	2.1
−31.	2.1
−24.	2.1
−21.	4.2
−18.	2.1
−17.	2.1
−16.	2.1
−14.	4.2
−13.	4.2
−12.	2.1
−11.	2.1
−10.	10.4
− 9.	2.1
− 8.	2.1
− 7.	4.2
− 6.	10.4
− 3.	6.3
− 2.	4.2
− 1.	2.1
0.	16.7*
1.	2.1
4.	2.1
6.	2.1
8.	2.1
9.	2.1
10.	2.1

*87.5% showed regression or no growth in social quotient

MEAN	−7.542	STD ERR	1.534	MEDIAN	−6.300

TABLE 23B: SOCIAL QUOTIENT SCORE CHANGE PER YEAR

MEAN	−.596	MEDIAN	−.585

PARC Ex. 54

ANALYSIS OF PROGRAMMING HISTORY OF PENNHURST CLIENTS PROPOSED FOR TRANSFER TO EMBREEVILLE

Responses to interrogatory number 1.11 were received for 68 clients proposed for transfer.

As of December 1976, the 68 people had been living at Pennhurst an average of 21.92 years.

The programs reported by the superintendent included certain unstructured activities such as "free time," and certain services such as public school and outside workshops which were not provided by Pennhurst. Nevertheless, all entries for all programming were included in this analysis. Many programs were reported without any duration or hours. These were not included. Approximately one out of eight programs had no hours reported.

The average time between a client's admission and the first reported program with hours attributed was 18.8 *years*.

The total number of hours of programming reported by the superintendant for the 68 people was 65,047. The 68 people have been at Pennhurst a total of 1,490 years. Thus, they are reported as having received 43.65 hours of programming per client per year. This translates to 7.2 minutes per client per day.

For the three years of programs with attributed hours, the 68 people were reported as having received 318 hours of programming per client per year. This translates to less than 1 hour per client per day.

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PARC Ex. 55

PENNHURST WAITING LIST
TOTAL N = 2382

TABLE 1: LEVEL OF MENTAL RETARDATION — COMPLETE COUNT

Unknown	13.6%
Unmeasureable	17.9%
Profound	7.8%
Severe	16.1%
Moderate	24.3%
Mild	20.3%

TABLE 2: AGE — ON BASIS OF SAMPLE OF 711 NAMES

	0-16	17-20	21-34	35+
N	(291)	(121)	(225)	(74)
%	41%	17%	32%	10%

Approximate mean age = 20 years

TABLE 3: STATUS — COMPLETE COUNT

County Of Residence	In Pennsylvania State Institution	In Other Facility	At Home Or Placement Unknown	
Chester = 97	4	36	57	(4%)
Bucks = 233	17	86	130	(10%)
Mont. = 355	24	170	161	(15%)
Delaware = 357	19	164	174	(15%)
Philadelphia = 1340	47	291	1002	(56%)
	III-4.7%	747-31.4%	1524-64.0%	

PARC Ex. 56

Pennhurst State School and Hospital
Spring City, Pa. 19475
Social Service Department

Dispersal — By Calendar Year (January through December)
January 1, 1972 through May 31, 1976

I. To Community Living Arrangements

Year	Total Placed for Year	Returned to Pennhurst	Deaths in Placement	Discharged	Remaining on Leave Status on Pennhurst rolls
1972	11	0	1	9	1
1973	66	10	0	15	41
1974	60	14	1	8	37
1975	34	1	0	1	32
1976	6	1	0	1	4
Total to 5/31/76	177	26	2	34	115

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II. To Other Community Placements

Year	Total Placed for Year	Returned to Pennhurst	To Other Pa. State Facility while on Leave	Deaths in Placement	Transferred To C.L.A. while on Leave	Discharged	Remaining on Leave Status on Pennhurst Rolls
1972	50	14	1*	2		26	7
1973	54	15			1	26	12
1974	30	5	1**			14	10
1975	14	2				8	4
1976	9					2	7
Total to 5/31/76	157	36	2	2	1	76	40

*White Haven State School and Hospital
**Embreeville MR Unit

Dispersal — by Calendar Year (January through December)
January 1, 1972 through May 31, 1976

III. To Pinehill Rehabilitation Center

Year	Transferred from Pennhurst	Paper Admissions	Returned to Pennhurst	Deaths	Discharged	Placed on Trial Visit	Remaining on Pennhurst Rolls
12/31/71	17			3	1		13
1972	81		2	8		3	68
1973	6	4	1				9
1974		20					20
1975	10	34		1			43
1976	1	4					5
Total to 5/31/76	115	62	3	12	1	3	158

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IV. To Embreeville MH and MR Units

Year	To MR Unit	To MH Unit
1969	73	
1972	68	1
1973	131	1
1974	64	1
1975	1	1
1976		1
Total to 5/31/76	337	5

* * *

Dispersal — by Calendar Year
(January through December)
January 1, 1972 through May 31, 1976

V. To Woodhaven Center

1974	13
1975	80
1976	3
Total to 5/31/76	96

* * *

VI. To Other State Facilities

1972	6
1973	8
1974	7*
1975	5
1976	5
Total to 5/31/76	31

*Includes one resident placed at Elwyn who remains on OAA Status on Pennhurst Census — all others have been removed from rolls.

June 18, 1976

Waiting List Statistics

January 1, 1972 — 2219
May 31, 1976 — 2282

	Applicants placed on the Waiting List	Removals from the Waiting List
1972	144	137
1973	107	103
1974	93	79
1975	111	91
1976	33	15
Totals	(488)	(425)

Reasons for Removal listed below:

Admitted to Pennhurst	240
Parents request	3
Out-of-State	9
Whereabouts unknown	23
BSU request — no contact	1
Elwyn State List	2
DPW request	3
Deceased	70
Married	1
High functioning level	4
No longer need for institutionalization	13
Admitted to other facilities or transferred to their waiting list:	56

Philadelphia State
Embreeville
Selinsgrove
Laurelton
Woodhaven

Del. Co. Home (Fair Acres)

Haverford State
White Haven
Cresson
Pinehill
Rest Haven Nursing Home
Riverview (residing at)

Prepared by Lou Wilson

PARC Ex. 58

Carryover — County MH/MR Program
Fiscal Year 1975-76
(From Fiscal Year 1974-75)

MENTAL HEALTH/MENTAL RETARDATION ADMINISTRATIVE UNITS (BY REGION)

	BASE	CLA	CLAC	FRS	DDS	TOTAL
Southeastern Region (5 units)						
1. Bucks County	157,971	32,767	-0-	-0-	-0-	190,738
2. Chester County	84,030	7,978	-0-	8,179	36,087	136,264
3. Delaware County	-0-	15,506	619	-0-	-0-	16,125
4. Montgomery County	260,774	79,869	-0-	-0-	-0-	340,643
5. Philadelphia	1,109,985	214,841	-0-	-0-	142,905	1,467,731
Sub-Total	1,612,760	350,961	619	8,179	178,992	2,151,511

* * * *

Northeast, Central and Western Regions Omitted

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Total Carryover By County MH/MR Unit
From Fiscal Year 1973-74

	BASE	CLA	CLAC	FRS	DDS	TOTAL
Southeastern Region (5 units)						
1. Bucks County	-0-	-0-	-0-	-0-	-0-	-0-
2. Chester County	62,752	1,437	4,587	25,679	4,143	98,598
3. Delaware County	-0-	112,332	13,979	-0-	-0-	126,311
4. Montgomery County	180,521	82,021	4,000	-0-	-0-	266,542
5. Philadelphia	-0-	321,026	-0-	142,611	18,105	481,742
Sub-Total	243,273	516,816	22,566	168,290	22,218	973,193

* * * *

Total Carryover By County MH/MR Unit
From Fiscal Year 1973-74

	BASE	CLA	CLAC	FRS	DDS	TOTAL
Southeastern Region (5 units)						
1. Bucks County	-0-	29,905	3,325	9,306	-0-	42,536
2. Chester County	29,793	5,232	-0-	2,011	-0-	37,036
3. Delaware County	-0-	-0-	-0-	-0-	62,898	62,898
4. Montgomery County	-0-	91,459	3,325	40,230	-0-	135,014
5. Philadelphia	911,783	606,475	-0-	104,597	188,302	1,811,157
Sub-Total	941,576	733,071	6,650	156,144	251,200	2,088,641

* * * *

A1021

County MH/MR Units	1 Gross Alloc., (Prog. Paymts. & C/O) (2 + 7)	2 1971-72 Carry-over	3 Base Alloc.*	4 Special Living Arrangements	5 Drug/Narc. Alcohol Progs.	6 DDS	7 Total Payments for Prog. (3+4+5+6)	8 SRS (4/30/72-3/31/73)	9 Total Payments to Counties (7+8)
Southeastern									
Bucks	1,850,878	162	1,503,937	53,345	293,434	-0-	1,850,716	120,510	1,971,226
Chester	1,121,581	65,825	730,611	92,415	232,730	-0-	1,055,756	33,343	1,089,099
Delaware	2,475,001	86,154	1,770,466	221,954	353,427	43,000	2,388,847	173,859	2,562,706
Montgomery	3,608,491	301,816	2,452,384	209,276	630,827	14,188	3,306,675	226,485	3,533,160
Philadelphia	21,369,543	1,395,142	17,216,933	801,758	1,435,390	520,320	19,974,401	3,773,836	23,748,237
Southeastern Total	30,425,494	1,849,099	23,674,331	1,378,748	2,945,808	577,508	28,576,395	4,328,033	32,904,428

* * * *

ALLOCATIONS AND EXPENDITURES FOR SOUTHEAST REGION

	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
1967-68						
Allocations						
Bucks	22,805					
Chester	22,022					
Delaware	10,750					
Montgomery	12,636					
Philadelphia	23,844					
	92,057					
Expenditures	(NOT AVAILABLE)					
1968-69						
Allocations						
Bucks	24,466					
Chester	30,311					
Delaware	27,435					
Montgomery	31,405					
Philadelphia	159,170					
	272,787					
Expenditures	(NOT AVAILABLE)					

	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
1969-70						
Allocations						
Bucks	846,952					
Chester	402,164					
Delaware	1,139,833					
Montogmery	1,224,165					
Philadelphia	10,986,503					
	14,599,617					
Expenditures						
Bucks	699,582					
Chester	352,105					
Delaware	816,813					
Montgomery	1,221,897					
Philadelphia	10,405,283					
	13,495,680					
1970-71						
Allocations						
Bucks	1,152,968					
Chester	592,601					
Delaware	1,400,116					
Montgomery	1,908,305					
Philadelphia	14,095,964					
	19,149,954					

	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
Expenditures						
Bucks	1,152,968					
Chester	563,403					
Delaware	1,233,698					
Montgomery	1,893,068					
Philadelphia	14,095,964					
	18,939,101					
1971-72						
Allocations						
Bucks	1,349,550	-0-	-0-	-0-	57,609	-0-
Chester	835,784	-0-	-0-	45,500	35,964	-0-
Delaware	1,679,991	-0-	-0-	82,481	78,357	44,020
Montgomery	2,342,525	-0-	-0-	262,801	107,229	23,680
Philadelphia	15,350,529	-0-	-0-	514,629	833,119	123,900
	21,558,379	-0-	-0-	905,411	1,112,278	191,610
Expenditures						
Bucks	1,349,550	-0-	-0-	-0-	57,609	-0-
Chester	799,440	-0-	-0-	22,800	28,840	-0-
Delaware	1,673,091	-0-	-0-	40,409	78,357	-0-
Montgomery	2,334,717	-0-	-0-	12,476	62,832	16,590
Philadelphia	15,350,529	-0-	-0-	-0-	76,511	-0-
	21,507,327	-0-	-0-	75,685	304,149	16,590

	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
1972-73						
Allocations						
Bucks	1,507,424	-0-	20,115	29,905	293,434	-0-
Chester	766,612	-0-	20,115	95,000	239,854	-0-
Delaware	1,770,525	-0-	32,184	231,842	353,427	87,023
Montgomery	2,455,709	-0-	40,230	416,046	675,224	21,282
Philadelphia	17,220,188	-0-	104,597	1,208,535	2,191,998	644,225
	23,720,458	-0-	217,241	1,981,328	3,753,937	752,530
Expenditures						
Bucks	1,507,424	-0-	9,306	29,905	251,346	-0-
Chester	736,819	-0-	2,011	5,232	229,854	-0-
Delaware	1,770,525	-0-	-0-	-0-	327,423	24,125
Montgomery	2,455,709	-0-	40,230	91,459	666,724	21,282
Philadelphia	16,305,150	-0-	104,597	606,475	578,893	455,923
	22,775,627	-0-	156,144	733,071	2,054,240	501,330
1973-74						
Allocations						
Bucks	1,661,906	-0-	100,993	64,490		-0-
Chester	891,874	-0-	72,137	142,392		24,500
Delaware	1,976,145	-0-	115,420	374,492		62,898
Montgomery	2,665,074	-0-	144,273	479,587		-0-
Philadelphia	18,802,267	-0-	375,106	1,184,865		214,212
	25,997,266	-0-	807,929	2,245,826		301,610

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	Base (Includes CLAC)	Pennhurst Dispersal	FRS	CLA	Drug/ Alcohol	DDS
Expenditures						
Bucks	1,661,906	-0-	100,993	64,490		-0-
Chester	824,535	-0-	4,458	140,955		20,357
Delaware	1,962,166	-0-	115,420	262,160		62,898
Montgomery	2,480,553	-0-	144,273	397,566		-0-
Philadelphia	18,802,267	-0-	232,495	863,839		214,212
	25,731,427	-0-	639,639	1,729,010		297,467
1974-75						
Allocations						
Bucks	2,059,749	2,115	112,852	198,793		-0-
Chester	1,134,964	-0-	60,379	235,208		41,143
Delaware	2,330,904	-0-	129,735	366,682		-0-
Montgomery	3,091,035	10,485	158,700	675,482		-0-
Philadelphia	20,538,588	14,562	257,300	1,394,579		329,251
	29,155,240	27,162	718,966	2,870,564		370,394
Expenditures						
Bucks	1,903,893	-0-	112,852	166,026		-0-
Chester	1,051,757	-0-	52,200	227,050		5,056
Delaware	2,330,285	-0-	129,735	351,176		-0-
Montgomery	2,836,246	4,500	158,700	595,613		-0-
Philadelphia	19,438,632	4,533	257,300	1,179,738		186,346
	27,560,813	9,033	710,787	2,519,603		191,402

	Base (Includes CLAC)	Dispersal	FRS	CLA	Drug/ Alcohol	DDS
1975-76						
Allocations						
Bucks	2,303,416	100,000	120,131	415,731		-0-
Chester	1,310,425	120,000	63,721	296,097		36,087
Delaware	2,822,219	-0-	135,151	493,155		-0-
Montgomery	3,329,917	10,650	168,936	685,141		-0-
Philadelphia	22,197,346	187,914	273,896	1,511,263		142,905
	31,963,323	418,564	761,835	3,401,387		178,992
Expenditures						
Bucks	2,303,416	100,000	120,131	415,731		-0-
Chester	1,310,425	111,155	63,730	284,272		36,08
Delaware	2,820,402	-0-	135,151	492,960		-0-
Montgomery	3,329,917	10,650	168,935	685,141		-0-
Philadelphia	22,197,346*	187,914*	273,896*	1,425,563*		142,90
	31,961,506*	409,719*	761,843*	3,303,667*		189,89

*Estimated

1976-77						
Allocations						
Bucks	2,530,133	353,180	141,883	726,103		
Chester	1,494,509	200,500	79,517	343,491		
Delaware	3,157,131	1,000	149,324	515,031		
Montgomery	3,688,637	420,000	168,936	950,966		
Philadelphia	24,293,047	460,320	314,809	1,586,132		
	35,163,457	1,435,000	854,469	4,121,723		

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PARC Ex. 63

Definitions of Community Living Arrangements Types

Type 1 *Developmental Maximation Unit:* An educational/residential program for the medically complex, multi-handicapped person, the establishing of a Developmental Maximation Unit is based on the belief that severely and profoundly retarded, multi-handicapped, medically complex individuals have developmental growth potentials, and can learn self-help skills. The primary objective of the Developmental Maximation Unit is to plan developmental programs directed towards moving each individual into a more normative residential and educational setting as quickly as possible. No more than twenty (20) individuals should reside in this type of program.

Type 2 *Intensive Behavior Shaping:* This residential program shall be for those persons not requiring Developmental Maximation care, yet not being ready to benefit from the more developmentally-and-training-oriented residential services. These individuals may be severely and profoundly retarded and/or may have very special problems. This residential service, most often a temporary one, emphasizes shaping and maintenance of basic habits. Each program is intended to serve up to a maximum of six individuals: 6 per home; 2 per apartment.

Type 3 *Structured Correctional:* This residential program for persons displaying serious behavior problems and consistently anti-social behavior consists of up to six persons, grouped by age (children's residence — aged 8-13, adolescent's residence — aged 14-18). This service should utilize a highly structured approach and inten-

sive supervision. Such an approach is necessary because of the dual considerations in providing a program which serves individuals who are both mentally retarded and delinquent. A structured correctional residence should be under the direction of an individual with experience in corrective habilitation.

Type 4 *Child Development:* The Child Development Program shall be for children from birth to age 18 who do not require Developmental Maximation care. This program shall enable children to develop self-help and social skills; toileting, feeding, dressing, communication, social courtesies, ambulation and/or mobility, etc. They will attend pre-school programs, public school classes, or appropriate day training programs. Each program is intended to serve 6 individuals; 6 per home; 2 per apartment setting.

Type 5 *Adult Long-Term Sheltered:* This residential service, for up to 8 individuals, is for those individuals who may not be capable of finding employment in competitive industry and will be retained in a vocational services center or day activity center for a prolonged period of time. The residential setting may be provided in a group home or apartments.

Type 6 *Adult Short-Term Training:* This residential service, for up to 8 individuals, is for adults, age 18 and over, who are involved in an active vocational training program or in some form of employment. This service should be intensively evaluation-and-training oriented. The typical length of stay should be about one year, as residents are expected to eventually move on into the community or another type of adult residence. The goal of this service is toward achiev-

ing the total, 24-hour self-sufficiency of the residents. Both group homes and apartments are utilized.

Type 7 *Adult Minimal Supervision:* This residential program shall be for those persons holding jobs in competitive or sheltered employment but who, if left to their own resources, might easily have experienced difficulty in finding or holding a job, in knowing how to recreate, and in working out problems of daily living. This program may utilize one of three different Apartment Living Models: (1) Apartment Cluster; (2) Co-Residence Apartment; and (3) Maximum Independence Apartments.

Type 8 *Family Relief:* This residential or non-residential service shall provide short-term care and supervision of persons who generally live in their own home. Maximum stay per residential admission should generally be one month at a time, and maximum resident time per client per year should be three months. This service is intended to: assist families surmount major and/or specific crises; relieve the continuity of family stress; and, to provide non-residential supervision for part of a day or evening, both for crisis as well as stress relief. Each program is intended to serve 12 individuals.

PARC Ex. 64

OFFICE OF MENTAL RETARDATION
DEPARTMENT OF PUBLIC WELFARE
COMMONWEALTH OF PENNSYLVANIA

COMMUNITY LIVING ARRANGEMENTS FOR MENTALLY RETARDED CITIZENS

Population and Dispersal Report Through June, 1976

Since Program was Initiated:

Through June 30, 1976

State Population in Programs	2,069
State Population Dispersed	1,368
Total State Population Served	3,437

As of June 30, 1976

Total State Population (In Programs)	2,069
Residents from State MR Institutions	853
Residents from State MH Institutions	74
Residents from Community	989
Residents from Private Licensed Facilities	139
From Nusing Homes	14
Dispersed to Independent Living	640
Dispersed to State Schools	157
Dispersed to Nursing Homes	29
Dispersed to Family	377
Dispersed to Foster Homes	70
Dispersed to Others	95

MONTHLY REPORT:

June 1 to June 30, 1976

State Population Entering Programs	48
State Population Dispersed	46

Total State Population Served during June in Programs and Dispersed 2,069 + 46 = 2,115

June 1 through June 30, 1976

State Population Entering Programs	48
Residents from State MR Institutions	13
Residents from State MH Institutions	1
Residents from Private Licensed Facilities	3
Residents from Nursing Homes	0
Residents from Community	31
Dispersed to Independent Living	8
Dispersed to State Schools	4
Dispersed to Nursing Homes	2
Dispersed to Family	27
Dispersed to Foster Homes	0
Dispersed to Others	5
Dispersal Total	46

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BREAKDOWN BY REGION

As of June 30, 1976

June 1 through June 30, 1976

	III Programs	From MR	From MH	From PLE	From Comm.	From MH	Entered Program	From MR	From MH	From PLE	From Comm.	From Nursing Homes
Southeastern Region	483	180	6	21	276	—	1	1	0	0	0	0
Northeastern Region	370	116	14	47	192	1	9	0	0	1	8	0
Central Region	525	239	21	54	208	3	20	6	0	2	12	0
Western Region	691	318	33	17	313	10	18	6	1	0	11	0

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DISPERSAL BREAKDOWN

Through June, 1976

June 1 through June 30, 1976

	Ind. Liv.	State Schools	Nurs. Homes	Ret. to Fam.	Fos. Homes	Ind. Liv.	State Schools	Nurs. Homes	Ret. to Fam.	Fos. Home
Southeastern Region	48	26	4	62	14	0	1	0	3	0
Northeastern Region	58	31	2	81	16	0	0	0	17	0
Central Region	166	45	7	89	22	4	1	2	1	0
Western Region	368	55	16	145	18	4	2	0	6	0
Totals	640	157	29	377	70	8	4	2	27	0

OTHER DISPERSAL CATEGORIES

	PLF	B.H.	MH	Training Facility	*CLA Residents Moving to Other CLA Programs
Southeastern Region	0	0	0	0	3
Northeastern Region	0	1	1	0	2
Central Region	0	0	0	1	6
Western Region	1	0	1	1	3
Totals	1	1	2	2	14

*NOT TO BE INCLUDED AS "DISPERSAL"

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COMMUNITY LIVING ARRANGEMENTS FOR MENTALLY RETARDED CITIZENS

POPULATION AND DISPERSAL REPORT FROM JULY 1, 1975 THROUGH JUNE 30, 1976

SUMMARY OF FISCAL YEAR 75-76

STATE POPULATION IN PROGRAMS AS OF JUNE 30, 1976	2,069
STATE POPULATION DISPERSED DURING FY 1975-76	558
TOTAL STATE POPULATION SERVED DURING FY 1975-76	2,627

DISPERSAL BREAKDOWN
(JULY 1, 1975 THROUGH JUNE 30, 1976)

	Indep. Living	State Schools	Nursing Homes	Ret. to Family	Foster Homes	Other	Total
Southeast	17	12	1	30	11	8	79
Northeast	35	14	0	62	10	8	129
Central	71	13	3	41	12	21	161
Western	58	13	10	82	4	22	189
Totals	181	52	14	215	37	59	558

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OFFICE OF MENTAL RETARDATION
DEPARTMENT OF PUBLIC WELFARE
COMMONWEALTH OF PENNSYLVANIA

COMMUNITY LIVING ARRANGEMENTS FOR MENTALLY RETARDED CITIZENS

OPERATIONAL DATA AS OF JUNE 30, 1976

Regions	Persons Funded	Residents In Programs	Group Homes	Apts.	Operating: Child Family Placement Homes	Operating: Adult Family Placement Homes
Southeastern	580	483	33	58	19	72
Northeastern	457	370	18	115	37	20
Central	529	525	36 + 2 DMU	82	16	41
Western	714	691	37	160	13	27
Totals:	2,280	2,069	124 + 2 DMU	415	85	160

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OPERATIONAL DATA BY REGION AND COUNTY
(AS OF JUNE 30, 1976)

Southeastern Region	Residents In Programs	Group Homes	Apts.	Operating: Child Family Placement Homes	Operating: Adult Family Placement Homes
Bucks County	37	3	8	0	0
Chester County	58	3	12	0	6
Delaware County	64	5	9	0	12
Montgomery County	106	7	11	19	12
Philadelphia County	218	15	18	0	48
Northeastern Region					
Berks County	55	4	19	4	0
Carbon-Monroe-Pike	33	4	6	3	1
Bradford-Tioga-Sullivan	31	3	5	5	0
Lack.-Sus.-Wayne	26	2	6	0	0
Luzerne-Wyoming	73	2	33	4	7
Schuylkill County	26	2	5	0	0
Lehigh County	84	1	25	20	1
Northampton County	42	0	16	1	11
Central Region					
Blair County	42	3	6	1	14
Cambria County	22	1	5	6	0
Centre County	26	3	2	0	0
Cumberland Perry	34	3	7	0	2
C-M-S-U	26	1	2	3	0
Dauphin County	78	4 + 1 DMU	11	0	5

Central Region	Residents In Programs	Group Homes	Apts.	Operating Child Family Placement Homes	Operating Adult Family Placement Homes
Hunt-Mifflin-Juniata	17	2	0	3	1
Lancaster County	68	5	13	0	0
Lycoming-Clinton	71	3	27	0	12
Somerset-Bedford	65	5	0	3	7
York-Adams	39	4	6	0	0
Franklin-Fulton	21	2	3	0	0
Lebanon	16	1 DMU	0	0	0
Northumberland	0	0	0	0	0
[PAGE 6] *Western Region*					
Allegheny County	252	6	100	0	0
Beaver County	20	1	6	0	0
Butler County	15	2	0	0	0
C-E-M-P	79	9	0	3	5
Mercer County	51	1	16	6	2
Clarion-Forest-Venango-Warren	42	2	3	2	15
Erie County	119	8	9	0	0
Armstrong-Indiana	7	1	1	0	0
Clearfield-Jefferson	16	1	10	2	0
Fayette	26	1	7	0	0
Washington-Greene	15	2	0	0	0
Westmoreland County	42	3	8	0	0
Crawford	0	0	0	0	0
Lawrence	7	0	0	0	4

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PARC Ex. 65

DEPARTMENT OF PUBLIC WELFARE

SUMMARY OF FISCAL ACTIVITY

FISCAL YEAR 1975-1976

Prepared By:
Bureau of Fiscal Management
August 20, 1976

COUNTY MH/MR PROGRAM

[59] The County MH/MR Program was appropriated $75.542 million State funds for Base Program services and $14.611 million for MR Programs for total appropriated funds of $90.153 million. An additional $6.0 million was also available for re-allocation from unspent State funds carried over from Fiscal Year 1974-75 programs. The total funds allocated to the counties during the year by type of service and source of funds is shown on the Total Commitments chart following these remarks.

In the Base Program a total of $75.2 million was allocated to the counties this year. The major portion of the funds, $63.9 million, provided for an 8% increase over each county's prior year expenditures which total $59.2 million. In addition, funding was provided to those counties with a per capita allocation of less than $4.00 to bring them up to this level. Also an allotment of $15.00 per day per unit of service was allocated to each county providing interim care for the mentally retarded. The balance of funds were distributed to counties providing for special projects such a. Pennhurst Dispersal, and various other deinstitutionalization pilot projects.

The Community Living Arrangements Program received a total of $13.8 million to provide for about 2,764 clients residing in CLA settings and an additional 1,389 people dispersed into the community or to State Schools or Nursing homes. Approximately 54% of the persons residing in CLA's were previous residents of State institutions.

In addition to the State funds available this year $1.3 million in Federal augmentations was available. The Public Health Service Grant of $639,324 was used to fund the Student Intern Program and mental health training and demonstration projects. The Developmen-
[60] tal Disabilities Service grant of $661,705 is used to fund training and demonstration projects for MR Programs.

This includes $352,022 which was carried over from the prior year and reallocated to the counties. A total of $13.8 million was earned and reimbursed to the counties from Federal Social Service funds during the fiscal year.

Among the fiscal policies for the County MH/MR Program addressed by the Department this year were the establishment of per diem rates for interim care based upon reasonable costs; clarification of overhead costs and the reporting of earned interest; and start up costs for fee-for-service programs such as short term inpatient and partial hospitalization. The Department also compiled and published a handbook containing all current fiscal policies relative to the administration of the County MH/MR Program.

The two charts which follow include the Total Commitments Summary and the Schedule of 1975-76 Allocations which lists allocations by categorical program and County MH/MR Unit.

COUNTY MH/MR PROGRAM
1975-76 Total Commitments

	Current Funds (State/Fed)	Carryover	Total Allocation
Base Program			
Base + 8% Cost of Living Increase	$63,932,893	-0-	$63,932,893
Full Yr. Cost of Special Projects	-0-	151,178	151,178
Student Intern Program	130,500	-0-	130,500
Interim Care	9,305,710	-0-	9,305,710
$4.00 Per Capita	830,017	-0-	830,017
Special Programs & Pilot Projects	1,039,898	278,455	1,318,353
Carryover Distribution	-0-	3,789,453	3,789,453
Total Base (Approp. 43)	$75,239,018	$4,219,086	$79,458,104
MR Programs			
CLA	11,734,175	1,591,489	13,325,664
CLA Coordinator	486,366	34,899	521,265
Family Resource Services	2,390,459	200,541	2,591,000
TOTAL MR (Approp. 57)	$14,611,000	$1,826,929	$16,437,929
Developmental Disabilities Services (Approp. 43)	-0-	352,022	352,022
Total County Grants	$89,850,018	$6,398,037	$96,248,055

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	Current Funds (State/Fed)	Carryover	Total Allocation
Administration			
State	403,482	-0-	403,482
Federal	682,196	166,311	848,507
TOTAL ADMINISTRATION (Approp. 43)	$ 1,085,678	$ 166,311	$ 1,251,989
Grand Total County Program	$90,935,696	$6,564,348	$97,500,044
State 43	$75,542,000	$4,219,086	$79,761,086
State 57	14,611,000	1,826,929	16,437,929
Federal PHS	635,500	3,824	639,324
Federal DDS	147,196	514,509	661,705

DEPARTMENT OF PUBLIC WELFARE

Comparison of Actual Commitments and Expenditures between 1974-1975 and 1975-1976 as of June 30, 1976
Mental Health/Mental Retardation Services

* * *

	1974-1975 Actual			1975-1976 Actual			Increase (Decrease) 1975-1976 Over (1974-1975)			Percent
	State	Augmen-tations	Total	State	Augmen-tations	Total	State	Augmen-tations	Total	Increase (Decrease)
Institutions for Mentally Ill Omitted.										
MR-ICF Units at State Hospitals										
Allentown	-0-	165,238	165,238	243,142	133,654	376,796	243,142	(31,584)	211,558	128.03
Clarks Summit	-0-	287,925	287,925	214,777	148,811	363,588	214,777	(139,114)	75,663	26.28
Embreeville	-0-	3,230,017	3,230,017	1,198,838	3,350,809	4,549,647	1,198,838	120,792	1,319,630	40.86
Harrisburg	870,240	17,845	888,085	297,428	776,753	1,074,181	(572,812)	758,908	186,096	20.95
Hollidaysburg	-0-	278,290	278,290	231,216	145,373	376,589	231,216	(132,917)	98,299	35.32
Mayview	345,373	66,748	412,121	304,767	366,504	671,271	(40,606)	299,756	259,150	62.88
Norristown	9,468	9,256	18,724	27,280	30,738	58,018	17,812	21,482	39,294	209.86
Somerset	-0-	499,859	499,859	438,053	150,242	588,295	438,053	(349,617)	88,436	17.69
Torrance	660,366	90,226	750,592	413,466	475,617	889,083	(246,900)	385,391	138,491	18.45
Warren	371,723	244,592	616,315	272,787	478,731	751,518	(98,936)	234,139	135,203	21.94
Wernersville	-0-	296,544	296,544	261,842	144,720	406,562	261,842	(151,824)	110,018	37.10
SUBTOTAL	2,257,170	5,186,540	7,443,710	3,903,596	6,201,952	10,105,548	1,646,426	1,015,412	2,661,838	35.76

	1974-1975 Actual			1975-1976 Actual			Increase (Decrease) 1975-1976 Over (1974-1975)			Percent
	State	Augmen-tations	Total	State	Augmen-tations	Total	State	Augmen-tations	Total	Increase (Decrease)
Institutions for Mentally Retarded										
Cresson	4,685,244	3,768,817	8,454,061	3,489,082	5,763,578	9,252,660	(1,196,162)	1,994,761	798,599	9.45
Ebensburg	7,355,843	6,323,248	13,679,091	5,793,925	9,400,147	15,194,072	(1,561,918)	3,076,899	1,514,981	11.08
Hamburg	4,379,781	5,512,857	9,892,638	4,413,829	7,097,490	11,511,319	34,048	1,584,633	1,618,681	16.36
Laurelton	3,495,879	3,808,642	7,304,521	4,196,157	4,276,937	8,473,094	700,278	468,295	1,168,573	16.00
Pennhurst	21,566,637	6,188,915	27,755,552	23,851,874	7,984,281	31,836,155	2,285,237	1,795,366	4,080,603	14.70
Polk	24,144,680	3,726,497	27,871,177	32,241,081	5,903,232	38,144,313	8,096,401	2,176,735	10,273,136	36.86
Selinsgrove	8,671,545	9,456,017	18,127,562	7,300,138	13,777,742	21,077,880	(1,371,407)	4,321,725	2,950,318	16.28
Southeastern	5,934,913	36,170	5,971,083	7,528,000	2,336,371	9,864,371	1,593,087	2,300,201	3,893,288	65.20
Western State Sch. and Hospital	7,202,595	3,726,513	10,929,108	6,695,367	5,356,503	12,051,870	(507,228)	1,629,990	1,122,762	10.27
White Haven	5,691,781	7,210,967	12,902,748	4,673,101	9,835,071	14,508,172	(1,018,680)	2,624,104	1,605,424	12.44
C. Howard Marcy	855,338	561,527	1,416,865	2,766,315	1,585,052	4,351,367	1,910,977	1,023,525	2,934,502	207.11
SUBTOTAL	93,984,236	50,320,170	144,304,406	102,948,869	73,316,404	176,265,273	8,964,633	22,996,234	31,960,867	22.15

Comparison of actual commitments and expenditures between 1974-1975 and 1975-1976 as of June 30, 1976 Mental Health/Mental Retardation Services

Additional Staff									
Allentown	$ 35,510	$ -0-	$ 35,510	$ -0-	$ -0-	$ -0-	$ (35,510)	$ -0-	$ (35,510)	(100.00)
Clarks Summit	22,771	-0-	22,771	-0-	-0-	-0-	(22,771)	-0-	(22,771)	(100.00)
Danville	82,951	-0-	82,951	-0-	-0-	-0-	(82,951)	-0-	(82,951)	(100.00)
Dixmont	25,826	-0-	25,826	-0-	-0-	-0-	(25,826)	-0-	(25,826)	(100.00)
Eastern St. Sch. and Hospital	59,247	-0-	59,247	-0-	-0-	-0-	(59,247)	-0-	(59,247)	(100.00)
Farview	13,700	-0-	13,700	-0-	-0-	-0-	(13,700)	-0-	(13,700)	(100.00)
Harrisburg	66,756	-0-	66,756	-0-	-0-	-0-	(66,756)	-0-	(66,756)	(100.00)
Haverford	78,135	-0-	78,135	-0-	-0-	-0-	(78,135)	-0-	(78,135)	(100.00)
Hollidaysburg	7,567	-0-	7,567	-0-	-0-	-0-	(7,567)	-0-	(7,567)	(100.00)
Mayview	50,209	-0-	50,209	-0-	-0-	-0-	(50,209)	-0-	(50,209)	(100.00)

	1974-1975 Actual			1975-1976 Actual			Increase (Decrease) 1975-1976 Over (1974-1975)			Percent
	State	Augmen-tations	Total	State	Augmen-tations	Total	State	Augmen-tations	Total	Increase (Decrease)
Norristown	122,318	-0-	122,318	-0-	-0-	-0-	(122,318)	-0-	(122,318)	(100.00)
Somerset	30,228	-0-	30,228	-0-	-0-	-0-	(30,228)	-0-	(30,228)	(100.00)
Torrance	58,425	-0-	58,425	-0-	-0-	-0-	(58,425)	-0-	(58,425)	(100.00)
Warren	33,699	-0-	33,699	-0-	-0-	-0-	(33,699)	-0-	(33,699)	(100.00)
Wernersville	17,034	-0-	17,034	-0-	-0-	-0-	(17,034)	-0-	(17,034)	(100.00)
Woodville	106,153	-0-	106,153	-0-	-0-	-0-	(106,153)	-0-	(106,153)	(100.00)
Cresson	118,326	-0-	118,326	-0-	-0-	-0-	(118,326)	-0-	(118,326)	(100.00)
Ebensburg	157,975	-0-	157,975	-0-	-0-	-0-	(157,975)	-0-	(157,975)	(100.00)
Hamburg	57,760	-0-	57,760	-0-	-0-	-0-	(57,760)	-0-	(57,760)	(100.00)
Laurelton	81,751	-0-	81,751	-0-	-0-	-0-	(81,751)	-0-	(81,751)	(100.00)
Pennhurst	290,572	-0-	290,572	-0-	-0-	-0-	(290,572)	-0-	(290,572)	(100.00)
Southeastern	7,770	-0-	7,770	-0-	-0-	-0-	(7,770)	-0-	(7,770)	(100.00)
Polk	158,279	-0-	158,279	-0-	-0-	-0-	(158,279)	-0-	(158,279)	(100.00)
Selinsgrove	191,242	-0-	191,242	-0-	-0-	-0-	(191,242)	-0-	(191,242)	(100.00)
Western	124,365	-0-	124,365	-0-	-0-	-0-	(124,365)	-0-	(124,365)	(100.00)
White Haven	45,431	-0-	45,431	-0-	-0-	-0-	(45,431)	-0-	(45,431)	(100.00)
C. Howard Marcy	456,000	-0-	456,000	-0-	-0-	-0-	(456,000)	-0-	(456,000)	(100.00)
SUBTOTAL	2,500,000	-0-	2,500,000	-0-	-0-	-0-	(2,500,000)	-0-	(2,500,000)	(100.00)
Resident Population Dispersal										
Polk	500,000	-0-	500,000	-0-	-0-	-0-	(500,000)	-0-	(500,000)	(100.00)
County Program										
Community Services	67,630,000	636,076	68,266,076	75,542,000	849,650	76,391,650	7,912,000	213,574	8,125,574	11.90
Small Units	13,596,000	940,998	14,536,998	14,611,000	-0-	14,611,000	1,015,000	(940,998)	74,002	.51
SUBTOTAL	81,226,000	1,577,074	82,803,074	90,153,000	849,650	91,002,650	8,927,000	(727,424)	8,199,576	9.90
GRAND TOTAL	$367,469,000	$123,647,531	$491,116,531	$389,632,000	$162,547,579	$552,179,579	$22,163,000	$38,900,048	$61,063,048	12.43

PARC Ex. 66

[1] **COUNTY MENTAL HEALTH & MENTAL RETARDATION PROGRAM**

Service Content of the Program **5200 Appendix IV**

Effective February 10, 1973 **DPW-MH&MR MANUAL**

MENTAL RETARDATION RESPONSIBILITIES

The County Program is the means by which minimum services as described in the Act shall be readily available to promote the social, personal, physical and economical habilitation or rehabilitation of mentally retarded persons with all due respect for the full human, social and legal rights of each person. This means that the health, social, educational, vocational, environmental and legal resources that serve the general population shall be marshalled and coordinated by the County Program to meet the personal development goals of mentally retarded persons, in accordance with the principle of normalization. *Normalization* means to ensure for every mentally retarded person and his family the right to live a life as close as possible to that which is typical for the general population. The mandated services, the provision of service mechanisms and the fiscal support of the program must all be used to secure for each person and his family the conditions and circumstances of day to day life that come as close as possible to representing normal life patterns.

In keeping with this principle of normalization, the County is responsible to utilize County Program funds for the mentally retarded to accomplish the following objectives:

1. Primary prevention of mental retardation — organic and functional;
2. Earliest possible case finding and diagnosis;
3. Medical and surgical correction or amelioration of systemic defects where possible;

[2] 4. Shaping and maintaining an environment most productive of basic human personality qualities involving parent-child and sibling relationships, environmental adaptation, self-awareness and learning motivation and ability;

5. Specific training and learning situations designed and implemented to develop all potential;

6. Community development and restructuring to achieve the maximum normalization for the mentally retarded person wherever he is.

I. Responsibility for Planning, Direction and Coordinated Delivery of Services — The Base Service Unit:

The County Administrator shall be responsible to provide for the establishment of an organizational unit consisting of multidisciplinary professional and nonprofessional staff capable to plan, direct and coordinate appropriate services for persons who are mentally retarded and in need of service from the County Program. This unit shall be called the Base Service Unit and the County Administrator shall have the authority to direct, control and monitor the activities of the Base Service Unit. The Base Service Unit shall be responsible to perform the following functions in such a way as to carry out the objectives of the County Program as stated above.

A. Establish or develop a system utilizing or developing preventive services in the community for the mentally retarded;

B. Establish and operate a system for earliest possible casefinding;

[3] C. Constitute a fixed point or referral and information for mentally retarded persons and their families;

D. Provide for comprehensive diagnosis and evaluation services to:

1. Diagnose, appraise and evaluate mental retardation and associated disabilities; define

the strengths, skills, abilities and potentials for improvement of the individual;

2. Assess the needs of the individual and his family;

3. Develop a practical life-management plan for the individual and his family and provide the necessary counseling and follow-along services.

4. Reassess the progress of the individual at regular intervals to determine his continuing need for service and/or for changes in his management plan (see Section II-A, 1, b (1) and (2)).

E. Maintain a continuing relationship with the mentally retarded person and with any facility or provider of service responsible for service to the mentally retarded person during any stage of his life management process;

[4] F. Initiate, develop and maintain a pattern of interaction between the diagnostic and evaluation team and others concerned with services to any mentally retarded person and/or his family. This pattern should emphasize, but not be limited to, participation of such persons in the life-management planning process as the family physician, local public health nurse, teacher, representatives of human service resources, vocational rehabilitation counselor, other providers of service, the family, advocates — informal or formal, and the mentally retarded person himself whenever possible;

G. Provide opportunities for advancing the knowledge and understanding of persons inside and outside its immediate setting, particularly those who have a responsibility in carrying out the life management process.

H. Foster cooperation through the use of a multidisciplinary approach;

I. Ensure that:

1. Where service to the mentally retarded is provided by other than the BSU and the mentally retarded person is referred for intake into the County Program, the referring agency and/or provider of service shall be invited to cooperate with the BSU in diagnosing, evaluating and planning for the person at that particular time of his life.

[5] 2. No service shall be authorized for funding by the County Program unless it is consistent with the life management plan as developed by the BSU and approved by the County Administrator.

II. Intake Into the County Program

A. All intake into the County Program shall be through the Base Service Unit.

1. The condition and circumstances of each person presumed to require service shall be thoroughly assessed before any disposition is made of his referral:

a. If it is determined after such assessment that the person does not at that time require further service from the BSU, the following information shall be recorded on the Intake and Proposed Service Plan, Form MH/MR 10:

(1) the presenting problem,

(2) the results of the assessment, and

(3) the disposition of the case (alternative referral of recommendation)

b. If it is determined after such assessment that the person requires service, he shall be provided with coordinated services necessary to identify: (1) the presence

[6] of mental retardation; (2) its cause and complications; and (3) the extent to which mental retardation limits (or is likely to

limit the person's daily living and work activities.

(1) These services shall include a systematic appraisal of said findings in terms of pertinent physical, psychological, vocational, educational, cultural, social, economic, legal, environmental and other factors of the mentally retarded person and his family:

(a.) To determine how and to what extent the disabling condition(s) may be expected to be removed, corrected or minimized by services;

(b.) To determine the nature and scope of services to be provided;

(c.) To select the service objectives which are commensurate to the person's interests, capacities and limitations;

(d.) To devise an individualized program of action to be followed, at the intervals needed, by periodic reappraisals; and

[7] (e.) To reevaluate progress of the person at intervals as necessary for such periodic appraisal.

(2) Each program service authorized shall have a service objective in keeping with each mentally retarded person's personal development goal, which goal shall be the basis for individualized life management planning.

(a.) This information shall be recorded on the Intake and Proposed Service Plan, Form MH/MR 10, along with a listing of the counseling, follow-along and other services to be provided within a specified period of time in coordinated association with the program service immediately authorized.

(b.) A specific date for evaluation of the person's progress and reevaluation of his life-management plan shall also be part of the Intake and Proposed Service Plan.

(c.) In all cases the mentally retarded person's family and the social, economic, cultural, educational, vocational, legal and
[8] environmental circumstances affecting him as well as his physical and psychological condition, shall be considered essential aspects of his life-management plan.

III. Aftercare Services:

Aftercare services shall be available to prevent unnecessary and prolonged institutionalization and to facilitate the return of persons to their homes or communities. These services shall be designed to enable persons who are mentally retarded to achieve their maximum potential for self-care, self-support, self-sufficiency and social competence.

A. Evaluation of persons currently in residential placement;

B. Preparation of individual life-management plans for persons in placement to include a definition of the special purpose served by such placement as part of the life-management plan of each individual;

C. Establishment of an individually appropriate and realistic personal/social development goal to be accomplished by each such placement;

D. Regular liaison with the facility to ensure:

1. That time spent in residence is limited to the time requirement to accomplish the established goal;

2. That service provided by the facility is consistently more suitable than the person might receive in the community.

[9] E. Pre-release counseling services to resident and family, referral with follow-through to appropriate com-

munity resources for post-release services, and follow-along responsibility for post-release life management.

F. Provision of short-term inpatient, emergency, outpatient, partial hospitalization and rehabilitation and training services when and as indicated by individual life-management plans;

G. Nursing home care for older individuals primarily in need of medically supervised nursing services;

H. Supervised sheltered personal care living arrangements (groups or singly) for those whose primary need is not medical;

I. Foster Home Care — individual and group living.

U.S. Ex. 5

Pennhurst State School and Hospital
Memorandum — Inappropriate Commitments

May 15, 1975

[-2-] The social service department, as responsible for the coordination of pre-admission and admission services, has made the courts, Base Service Units, and MH/MR Centers aware of administrative policy of our facility in regard to admissions. All of these agencies are aware of Pennhurst's physical conditions and understaffing. It has been the thrust of the social service department to insure the seeking out and use of every possible alternative service for the person needing residential care and locating of appropriate community services for those not in need of residential care.

In effect, we oppose every commitment to Pennhurst. Some are opposed more vehemently than others. In the case of children and adults who urgently need residential care, who are appropriate candidates for admission, and for whom there is no other alternative, we are less vocal in our opposition. For others, there is clear indication that Pennhurst is not an appropriate facility for their needs, and in these situations strong opposition has been raised against commitment here. Referring and committing agencies have and have not been sensitive to the inappropriateness of commitment here.

The following selected cases illustrate instances where we have vehemently opposed admission yet the children and adults were committed here:

1972 commitments:

_____ b. 4/28/72 — adm. 8/2/72 — BSU, Hall-Mercer committing court — Philadelphia Court of Common Pleas, Family Court Division. This commitment was opposed because of Pennhurst's inability to provide the care needed by a child so young and on the basis that retardation

could not be documented. Although committed to Pennhurst, _____ was transferred to St. Joseph's Children and Maternity Hospital, Scranton, shortly after her admission.

_____ b. 10/5/56 — adm. 8/18/72 — BSU, Episcopal committing court — Philadelphia Court of Common Pleas, Family Court Division. Commitment was opposed on basis of Pennhurst being inappropriate for _____'s needs. _____ was transferred to Embreeville Environmental Enrichment Program November 27, 1972.

1973 commitments:

_____ b. 8/17/58 — adm. 12/27/73 — BSU, Chester-Crozier committing court — Delaware County Juvenile Court. Commitment was opposed on the basis that Pennhurst could not appropriately provide for _____'s needs. He was seen as a culturally deprived young man and retardation was questioned. Upon admission, psychological evaluation indicated _____ was not retarded. Despite efforts to find a more adequate placement, _____ remained at Pennhurst until transfer to Youth Forestry Camp in March, 1975.

[-3-] 1974 commitments:

_____ b. 1/27/14 — adm. 5/1/74 — BSU, PATH committing court — Philadelphia County Court of Common Pleas — Master's Hearing. Commitment was opposed on the basis of _____'s needs being geriatric as he was 60 years of age. _____ was committed here with BSU and Pennhurst State School to pursue appropriate placement. No facility has yet been located for _____ and he remains at Pennhurst.

_____ b. 7/18/06 — adm. 8/19/74 — BSU, Penn Foundation committing court — Bucks County Court of Common Pleas. Commitment was made without knowledge to us. _____ arrived at

Pennhurst without any notice. Following evaluation here, nursing home placement was recommended to and secured by the Base Service Unit. Is doing well at the nursing home and was discharged from Pennhurst in March, 1975.

_____ b. 10/23/59 — adm. 9/11/74 — BSU, Philadelphia Psychiatric Center — committing court — Philadelphia County Court of Common Pleas — Family Division. Commitment was opposed on the basis of _____'s level of functioning — retardation was questionable and our resulting inability to provide appropriate programming to meet his needs. He was committed to Pennhurst for 60 days pending evaluation and referred to Woodhaven on January 29, 1975 after court intervention. Psychological evaluation here indicated _____'s functioning to be above the retarded level.

1975 commitments:

_____ b. 7/15/50 — adm. 3/26/75 — BSU, Hahnemann committing court — Philadelphia County Court. We received notice of hearing for commitment for _____ the morning of 3/12/75. Hearing was scheduled for afternoon of 3/12/75. Philadelphia Public Defenders office was told we had no information about _____, therefore we were not in a position to accept him. Suggested inpatient evaluation at BSU for evaluation. _____ was committed to Pennhurst State School on March 12, 1975. BSU representative at the court hearing was not permitted to testify. Commitment is felt to be inappropriate as _____ requires more structured program than we can provide.

_____ b.d. 7/9/64 — adm. 4/21/75 — BSU, Philadelphia Psychiatric Center. Despite our opposition, _____ was admitted on a voluntary admission by order of the Regional Commissioner of Mental Retardation. Although recognizing the family's

need for relief of the care of_____, admitting this child on a voluntary application superceded the rights of other families who have been required to gain admission to Pennhurst through the court process.

I hope this will be helpful.

U.S. Ex. 15

Cumulative Accident Summary (12/29/76 - 1/29/77)

	Date	Who	Location and Action
Major:	1/21/77		3 sutures on forehead.
	1/18/77		3 sutures on eyebrow.
	1/16/77		Fracture finger.
	1/1/77		Cut own arm deliberately, sutured.
	1/17/77		Laceration of left side of forehead — 3 sutures.
	1/8/77		Laceration of occipital area — 4 sutures.
	1/2/77		Laceration of lower lip — 6 sutures.
	1/3/77		Laceration on back of head — 5 sutures.
	1/5/77		Laceration of nostril — sutured at Phoenixville Hosp.
	1/12/77		Laceration on back of scalp — 3 sutures.
	1/19/77		Laceration of forehead — 3 sutures.
	1/13/77		Laceration on left side of head — 2 sutures.
	1/12/77		Laceration on occipital area — 3 sutures.
	1/23/77		Laceration over eyebrow — 9 sutures, laceration on nose — 4 stitches.
	1/4/77		Possible dislocation.
	1/8/77		Broken foot.
	1/3/77		Sutured finger.
	12/29/76		Loose tooth, extracted.
	1/10/77		Lacerated head, 3 sutures.
	12/31/76		Lacerated head, 3 sutures.
	1/25/77		Lacerated head, 1 suture.

Date	Who	Location and Action
1/21/77		Lacerated head, 3 sutures.
1/21/77		Head, self-inflicited, sutured.
1/26/77		Cut right eyebrow, 4 sutures.
1/12/77		Fall, 6 sutures to brow.
	25	

Minor:	Self	299	+ 41	=	340
	Others	240	+ 43	=	283
	Misc.	162	+ 48	=	210
					833

Accident Summary (Tabulation on 3/1/77)

Totals to All Units (1/29 - 2/28/77)

	Date	Who	Location and Action
Major:	2/5/77		Fall, suture eyebrow.
	2/14		Pushed, suture lip.
	2/4		Cut forehead, 4 sutures.
	2/18		Fracture toe.
	2/9		1 suture to forehead.
	2/24		Cut left brow, 5 sutures.
	2/19		Cut left brow, 3 sutures.
	2/17		Cut right brow, 4 sutures.
	2/3		Cut brow, 4 sutures.
	2/6		Cut forehead, 4 sutures.
	1/30		Fell, lost tooth.
	2/5		Bit in lip, 6 sutures.
	2/2		Fell, 4 sutures to head.
	2/8		3 sutures to scalp.
	2/14		Cut finger, 4 sutures.
	2/6		Cut eye, opthamologist.
	2/13		Fell, 3 sutures to head.
	2/15		Ran, fell and cut lips and gums. Sutured.
	2/11		Cut shoulder on bed frame, 3 sutures.
	2/24		Cut brow, 3 sutures.
	2/25		Cut brow, 2 sutures.
	?		Cut brow, sutured.
	2/5		Cut brow, 7 sutures.
	2/4		Bit ear, 10 sutures.
	2/15		Cut brow, 4 sutures.
		25	

Minor:	Self	129
	Others	230
	Misc.	205
		564

Accident Summary (Tabulation on 3/1/77)

Unit	Major	Minor - Self	Others	Miscellaneous	Minor
1	1	10	15	5	30
2	2	18	11	12	41
3	2	17	15	16	48
4	3	15	3	10	28
5	3	10	36	21	67
6	2	8	32	40	80
7	6	15	35	31	81
8	4	23	28	10	61
9	2	13	55	69	137
Hosp. — No Reports					543

Submitted by J. F. Brody, Ph.D.

keg

cc: Executive Staff
Unit Directors
H. Francis
D. Pool
J. Hipple

U.S. Ex. 48 (INDEX)*

Photographic exhibits:

Dr. Clements: (3/26/75)

Photo	Ward	
1	C-9	Bathing of residents (Non-amb. female bathing area)
2	C-9	Dorm area (Non-amb. female bedroom)
3	C-9	Resident in bed
4	K-1	Residents in wheelchairs Ward K-1 dayroom
5	K-1	Toilets
6	K-1	Bathroom radiator & pipe
7	K-1	Bathroom sinks
8	K-2	Male dayroom
9	K-2	Bedroom
10	K-2	Toilets
11	C-9	Wooden cart in female non-amb. ward
12	C-9	Non-amb. female dayroom
13	D	Basement — Motor training room
14	D-3	Child in dayroom floor
15	D-2	Bedroom
16	D-2	Bedroom
17	D-4	Bedroom
18	Q-1	Male in restraints
19	Q-2	Bedroom
20	H-1	Child in bed
21	48	Dayroom
22	52	Run in corner at end of hallway
23	52	Men asleep on floor
24	52	Boy asleep on dayroom floor
25	52	Boy's scarred head
26	47	Dayroom
27	47	Dayroom

*Photographs admitted into evidence as U.S. Ex. 48 are presented to the Court in a separate volume of the Appendix.

28	47	Female on dayroom floor
29	47	Bedroom
30	47	Bedroom
31	48	Dayroom
32	48	Corridor
33	50	Dayroom (3 females, TV, connecting door)
34	Bldg 2	Dining area in basement
35	Bldg 2	Bedroom
36	Unit 3	Basement dining area — Female eating dinner
37	Unit 3	Basement dining area — Female taking anothers food
38	C-8	Aide giving medication to resident
39	C-13	Showers
40	C-12	Sleeping area (non-amb.)
41	C-12	Sleeping area (non-amb.)
42	C-8	Towels on hallway floor
43	C-8	Female exiting shower
44	C-8	Aide drying resident

Photographic exhibits:

Dr. Roos: (4/7/75)

Photo	Ward	
45	D-1	Bed with restraints
46	K-1	Bathroom with 3 residents
47	Hospital	Male in restraints
48	Hospital	Female in restraints
49	Hospital	Blind female in restraints
50	C-4	Uncleaned toilet
51	C-14	Young lady

(3/1/77)

52	H-2	Women residents in dayroom
53	Q-1	Resident by radiator in sleeping area
54	Q-1	Same resident lying on dayroom floor
55	C-6	New Horizons resident on hallway floor

Photographic exhibits:

Dean Settle:

Photo	Ward	
56	C-6	New Horizons residents in dayroom
57		DELARC work activity center — Upland
58		DELARC — Upland
59		660 Burmont Rd. — resident in dining room
60		660 Burmont Rd. — resident with pet Afghan "Bixby"
61		Pennhurst resident
62	M-2	Resident
63		Pennhurst resident
64		Pennhurst resident
65		Resident in Pennhurst workshop
66		Resident in Pennhurst workshop
67		Resident in Pennhurst workshop
68		Pennhurst workshop

Photographic exhibits:

Linda Glenn:

Photo	Ward	
69		500 N. Franklin (Pottstown) women resident in living room
70		Interac 300 Parker Ave. Apts.
71		300 Parker Ave. Apt. living room
72		1314 Federal St. — women residents in kitchen
73		6224 Wissahickon Ave. — boys in living room
74		6224 Wissahickon Ave. — outside of home
75		EMAN 143 E. Mt. Airy — 3 women residents
76		143 E. Mt. Airy — outside of home
77		EMAN 143 E. Mt. Airy — view from porch
78		Interac Shoremont Apts. bathroom
79		Interac Shoremont Apts. — resident in bedroom
80		Interac Shoremont Apts. — resident by bedroom closet
81		EMAN 729 Vernon Rd. Kitchen
82		EMAN 729 Vernon Rd. Bathroom
83		EMAN 729 Vernon Rd. — resident in his room by T.V.

Photographic exhibits:

Dr. Girardeau:

Photo	Ward	
84		West Chester Apts. — bedroom
85		West Chester Apts. — residents
86		River Crest School — activities center
87		River Crest School — activities center
88		River Crest School — activities center
89		MARC Infant Motivation Program
90		2923 Garrett Rd. apt. living room
91		Garrett Rd. apt. bedroom
92		Lynch Home — children
93		DELARC work activity center
94		Keystone Learning Center — class in session
95		Keystone Learning Center — noon meal
96		Mod unit #2 dining area
97	Q-1	seclusion room bed
98	Q-1	seclusion room pipe
99	Q-1	basket ball court/dayroom & 2 residents
100	D-4	time out room (inside)
101	D-4	time out room (outside)
102	D-3	sleeping area
103	D-1	day room and residents in wheelchairs
104	T-2	regular entrance to ward
105	T-1	toilets
106	T-1	showers
107	T-1	sleeping area
108	T-1	day room and residents

IN THE

SUPREME COURT OF THE UNITED STATES

Supreme Court, U. S.
FILED
MAY 5 1980
MICHAEL RODAK, JR., CLERK

October Term, 1979

Nos. 79-1404, 79-1408,
79-1414, 79-1415 and 79-1489

PENNHURST STATE SCHOOL
AND HOSPITAL, *et al.*,

Petitioners

v.

TERRI LEE HALDERMAN, *et al.*,

PENNSYLVANIA ASSOCIATION FOR RETARDED
CITIZENS, *et al.*

and

UNITED STATES OF AMERICA,

Respondents

ON PETITIONS FOR WRIT OF
CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION OF RESPONDENTS TERRI LEE HALDERMAN, *et al.*

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May 5, 1980

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I. There is no basis for review of a purely local law question where the District Court and the Court of Appeals *en banc* reasonably and correctly interpreted dispositive and definitive Pennsylvania statutory and case law providing an enforceable right to habilitation to the retarded. 9

II. The decision below correctly holds that Congress granted retarded people a privately enforceable right to habilitation appropriate to the individual. 14

III. Where petitioner government officials adamantly refuse to remedy their violations of respondents' rights and where protection of state and federal statutory rights would otherwise be impossible, appointment of a master with circumscribed supervisory duties does not violate principles of federalism. 21

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IV. Where a unitary plaintiff class is certified for the purpose of determining liability, and where procedural alternatives to decertification are available to resolve any possible problem, and where there is no substantial conflict regarding plaintiffs' claims, the Court of Appeals *en banc* did not abuse its discretion in declining to decertify the class. 24

V. There is no conflict with any decision of this Court or among the courts of appeals. 26

VI. The Questions Presented are not appropriate for review. 27

Conclusion 28

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Legislative Materials:

S. Rep. 94-160, 94th Cong., 1st Sess. (1975) . . 14, 19

H. Conf. Rep. 94-473, *reprinted at* 2 U.S. Code & Ad. News 943 (1975) 16, 17, 19

121 Cong. Rec. 16,516; 16,519; and 29,820 (1975) 17

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1979

Nos. 79-1404, 79-1408,
79-1414, 79-1415 and 79-1489

PENNHURST STATE SCHOOL
AND HOSPITAL, *et al.*,

Petitioners

v.

TERRI LEE HALDERMAN, *et al.*,

PENNSYLVANIA ASSOCIATION FOR RETARDED
CITIZENS, *et al.*

and

UNITED STATES OF AMERICA,

Respondents

ON PETITIONS FOR WRIT OF
CERTIORARI TO THE UNITED STATES COURT
OF APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION OF RESPONDENTS TERRI LEE HALDERMAN, *et al.*

OPINIONS BELOW

The opinion of the Court of Appeals for the Third Circuit *en banc*, dated December 13, 1979, is reported at 612 F.2d 84 (3d Cir. 1979) and appears at 89a *et seq.*[1]

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1. Record references are to the "Joint Appendix" filed by the Commonwealth and County petitioners at Nos. 79-1404, 79-1408 and 79-1415.

The opinion of the District Court, dated December 23, 1977, is reported at 446 F.Supp. 1295 (E.D. Pa. 1977), and appears at 6a *et seq.* The District Court's opinion and judgment of March 17, 1978, reported at 446 F.Supp. 1295 E.D. Pa. 1978), appears at 76a *et seq.*

JURISDICTION

Petitioners invoke the jurisdiction of this Court pursuant to 28 U.S.C. §1254(1). The decision of the Court of Appeals for the Third Circuit is dated December 13, 1979.

QUESTIONS PRESENTED

1. Is there any basis for review of a purely local law question where the District Court and the Court of Appeals *en banc* reasonably and correctly interpreted dispositive and definitive Pennsylvania statutory and case law providing an enforceable right to habilitation to the retarded?

2. In the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§6000, *et seq.*, did Congress grant retarded people a privately enforceable right to habilitation appropriate to the individual?

3. Where government officials adamantly refuse to remedy their violations of rights and where protection of state and federal statutory rights would otherwise be impossible, does appointment of a master with circumscribed supervisory duties violate principles of federalism?

4. Where a unitary plaintiff class is certified for the purpose of determining liability, and where procedural alternatives to decertification are available to resolve any problem, and where there is no substantial conflict re-

garding plaintiffs' claims, did the Court of Appeals *en banc* abuse its discretion in declining to decertify the class?

STATUTORY PROVISIONS INVOLVED

Pennsylvania Mental Health and Mental Retardation Act of 1966, 50 P.S. §§4101, *et seq.* . . . 225a

Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§6000, *et seq.*[2] 198a

2. The "Joint Appendix" fails to set forth the entire federal statute. However, petitioner in No. 79-1489 has reproduced the entire statute in Appendix D to its petition, at 171a therein.

STATEMENT OF THE CASE

Respondents submit this statement of the case because the petitioners' statements do not discuss the facts, exclude or incorrectly characterize critical portions of the procedural history and misstate the judgment of the lower court.

Introduction. Pennhurst State School and Hospital, near Valley Forge, Pennsylvania, is an institution for the retarded which housed 1230 retarded individuals at the time of trial. 104a. Although divided on the legal standard of care for the retarded, the Court of Appeals *en banc* was unanimous in condemning, in the words of the dissent, the "[u]nderstaffing, filth, violence, enforced inactivity, and other horrors [which] make Pennhurst, in the opinion of one well-traveled expert, one of the worst institutions of its kind in the world." 162a.

"Neither the Commonwealth nor the County defendants take serious issue with the court's findings of fact respecting the abominable conditions to which Pennhurst residents have been subjected," the majority declared. 103a. In this context, the entire court below agreed that "the federal courts have a right and duty to intervene," 162a, and that "improvement of Pennhurst [is] mandatory." 163a. The issue in this case is the extent and nature of the duty to intervene to protect the health, education and well-being of the institutionalized retarded at Pennhurst.

Relying on an independent state statutory ground, the Pennsylvania Mental Health and Mental Retardation Act, and a federal statute, the Developmentally Disabled Assistance and Bill of Rights Act, the Court of Appeals for the Third Circuit held that retarded people have a right to habilitation, a non-medical educational process, in a setting determined on the basis of individual need and that Pennsylvania state and local officials have a statutory duty to implement such habilitation.

Carefully toeing the lines set by the dispositive statutes and decisions of this Court, and in the absence of any conflict with other Courts of Appeal, the Third Circuit's judgment is unremarkable.

Proceedings in the District Court. On May 30, 1974, Terri Lee Halderman, a retarded inmate of the Pennhurst institution, commenced this class action against Pennsylvania state officials alleging, on behalf of all inmates, that they were subject to chronic abuse and neglect, causing physical and intellectual regression, lack of supervision, inhumane and dangerous conditions, and a denial of appropriate non-institutional care. *See* 15a, 94a-95a. Halderman filed a first amended complaint on July 29, 1974, adding as plaintiffs seven other retarded individuals and the Parents and Family Association of Pennhurst, organized in 1967 and representing 200 parents of retarded citizens at Pennhurst. 16a.

The United States was granted leave to intervene as plaintiff on January 17, 1975, its complaint citing the same conditions as the Halderman plaintiffs. 16a, 95a.[3] The Pennsylvania Association for Retarded Citizens (PARC) and several Pennhurst residents were granted leave to intervene November 12, 1975, 16a, and, thereafter, Halderman and PARC amended their complaints to seek relief against those Commonwealth and County defendants who were responsible for commitment of retarded people to Pennhurst and the underuse and lack of structured supervised community facilities. 96a. Violations of constitutional rights were alleged, as were violations of state and federal statutory rights. 96a. The certified class consisted of persons at Pennhurst and those in the local geographical area who might be institutionalized in the facility. 14a, 96a.

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3. Petitions for mandamus, stay and certiorari to prevent United States participation at trial were later denied. 16a, 95a; *Beal v. Broderick*, 431 U.S. 933 (1977).

District Judge Raymond J. Broderick presided over the non-jury trial which began on April 18, 1977 and ended on June 13, 1977, occupying thirty-two court days. 15a. The District Court's opinion issued December 23, 1977, exhaustively finding the facts and holding, on independent alternate grounds, that state and federal statutes, and the United States Constitution, were violated by the petitioners.

After holding them liable, Judge Broderick provided three opportunities for petitioners to submit a plan for vindication of respondents' rights. First, he directed the parties to meet in court to attempt to achieve an acceptable order. 77a-78a. That being unsuccessful, he directed submission of proposed orders. 78a. Finally, he held a hearing to receive any additional evidence on relief. *Id.* On March 17, 1978, the trial court entered its judgment for plaintiffs below, respondents here. 79a *et seq.*

After judgment and after appeals were filed to the Court of Appeals, on April 13, 1978, an organization of Pennhurst employees and parents who favor institutional care sought to intervene. Intervention at that point in time was denied to the Pennhurst Parents-Staff Association.[4]

Proceedings in the Court of Appeals. Defendants in the trial court filed appeals to the Court of Appeals for the Third Circuit, where the case was argued to a panel on January 9, 1979 and to the court *en banc* September 6, 1979.

On December 13, 1979, the Court of Appeals, divided 6-3, affirmed the District Court's determination of liability on state and federal statutory grounds only, and

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4. Intervention was granted to this group for the purpose of participation in formulation of relief, by order of the District Court, dated February 22, 1980.

modified the lower court's decree. 89a *et seq.* It is from this decision that the present petitions for certiorari are filed.[5]

The Judgment of the Court of Appeals. "At the time of trial, Pennhurst housed 1230 mentally retarded individuals, some of whom also suffered from physical disabilities. The residents are not mentally ill, have broken no laws, and are not a danger to others, although, in severe cases, some are unable to care for themselves. Mental retardation is an impairment in learning capacity and adaptive behavior, and is not treatable, like mental illness, by means of drugs or psychotherapy. While the mentally retarded do suffer educational difficulties, the level of their functioning can be improved by individual training." Court of Appeals at 104a.

Pennsylvania's retardation system requires that each retarded person be assigned to a county Base Service Unit "responsible for arranging community and institutional placements and coordinating services for the individual." 45a; *see* 104a. Through their acts and legal obligations, county petitioners are liable for failing to provide services to respondents and for "consigning the mentally retarded to inadequate living conditions." 45a-46a, 104a, 107a, 129a-130a.

In harsh language, the District Court and the Court of Appeals described and condemned the "abominable,"

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5. Petitioners in No. 79-1404 are Pennhurst State School and Hospital and various state officials, collectively referred to as the "Commonwealth petitioners." Petitioners in No. 79-1408 are Philadelphia County officials and those in No. 79-1415 are officials of Bucks, Chester, Delaware and Montgomery Counties, collectively referred to as the "County petitioners." Petitioner in 79-1489 is the Pennhurst Parent-Staff Association.

In No. 79-1414, Pennsylvania Association for Retarded Citizens and three retarded people, plaintiffs below, have filed a conditional cross-petition for certiorari on two limited issues. Respondents Terri Lee Halderman, *et al.*, join in this cross-petition only if the certiorari petitions should be granted.

103a, conditions to which Pennhurst State School and Hospital inmates are involuntarily[6] subjected. 18a-40a, 106a. The dissenting judges in the Court of Appeals similarly stressed the "deplorable conditions" which justify finding Pennhurst "one of the worst institutions of its kind in the world." 162a. Deterioration, regression, physical injuries, sexual assaults, deaths, misuse of dangerous drugs, solitary confinement, inadequate and unavailable programs, outbreaks of infectious disease, urine and excrement in living areas, and general disregard of minimal professional standards characterize the facts of life at Pennhurst. 18a-40a, 106a.

Considering the "shortcomings of institutions as places for habilitation," 155a, and the fact that "[m]any individuals now living at Pennhurst could be moved immediately into the community and would be able to cope with little or no supervision," 43a, the Court of Appeals held that every plaintiff class member has a right to an *individual* assessment of his or her needs and a determination of "the appropriateness of an improved Pennhurst for each such patient." 156a.

Reversing the trial court's orders that Pennhurst be closed and admissions halted, the Court of Appeals stressed that some individuals may require institutional care and held "it is only fitting that the Commonwealth be required to undertake a case-by-case investigation into how each person's rights may best be facilitated." 157a.

In reaching this conclusion, the court below relied on state stututory and case law to find an independent state right to habilitation, 122a-130a, thereby avoiding adjudication of constitutional issues. 108a. The Court of Appeals' decision also found an enforceable federal statutory right to habilitation.

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6. Both courts below found that "the notion of voluntariness in admission and retention" is "illusory." 108a, 40a-41a. Respondents, as a matter of fact, are held involuntarily. *Id.* Petitioners do not challenge this finding.

REASONS THE WRITS SHOULD BE DENIED

I. There is no basis for review of a purely local law question where the district court and the Court of Appeals *en banc* reasonably and correctly interpreted dispositive and definitive Pennsylvania statutory and case law providing an enforceable right to habilitation to the retarded.

Pennsylvania statutory and case law guarantees retarded persons the right to habilitation. The Court of Appeals found that state law provides an independent ground upon which the judgment below firmly rests. In this circumstance, review by this Court would be unprecedented, particularly inappropriate and ineffective.[7]

The state law right to minimally adequate habilitation, recognized by both the district court, 68a-70a, and the Court of Appeals, 122a-130a, has been the basis for decision after decision in the Pennsylvania state courts mandating the provision of appropriate services, in the community if indicated, for retarded persons. *See e.g., In re: Joyce Z.*, 123 Pitt.L.J. 181 (Allegheny Cty. 1975); *In the Matter of Anthony S.*, No. DP 1521-75-11 J 198159

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7. The Court does not appear to have ever accepted for review a case in which state law was dispositive and then to have reversed the interpretation of state law provided by the lower courts. *Cf. Thompson v. Consolidated Gas Utilities Corp.*, 300 U.S. 55 (1937) (no state court decision issue; constitutional issue reached); *Elkins v. Moreno*, 435 U.S. 647 (1978) (Court *sua sponte* certified to state court undecided question bearing on state's relations with foreign nations, other states and the federal government.)

Petitioners cite three inapposite cases to support their unprecedented claim that review of the state law decision is necessary. *Murdock v. City of Memphis*, 20 Wall. 590 (1875) (on jurisdiction over judgments of state courts); *Stoner v. New York Life Insurance Co.*, 311 U.S. 464 (1940) (diversity case; federal court must follow state court decision in earlier suit between the same parties on the same question); *Huddleston v. Dwyer*, 322 U.S. 232 (1944) (diversity case; federal court reviewing case on appeal must apply newly decided law).

(May 16, 1977, Philadelphia Cty. Juvenile Court); *In the Interest of Angelo P.*, No. J 194137 (December 6, 1976, Philadelphia Cty.); *In the Interest of Stephanie Lamb*, No. J-184929 (June 30, 1977, Philadelphia Cty.); *In the Interest of Maria O'Hara*, No. 248 Dec. Term, 1976 (April 7, 1977, Philadelphia Cty.); *In the Interest of Edwin Ward*, Nov. Term, 1977 (February 23, 1978 and March 6, 1979, Philadelphia Cty.); *In the Matter of Benjamin Jefferson*, No. 096177, 083977 (November 28, 1978, Chester County); *In the Interest of Moises Santiago*, No. 41-CS-1978 (Chester County); *In the Interest of Mary Alice S.*, No. 75-11919 (April 13, 1976, Delaware Cty.); *In the Interest of Anthony Hariss*, No. 17034 (April 27, 1976, Delaware Cty.); *In the Interest of Carvella Ebron*, No. J-181877 (March 19, 1979, Philadelphia Cty.); *In re Joseph Schmidt*, No. CC 660 (February 13, 1979, Allegheny Cty. Orphans Court); *In the Interest of Kenneth P.*, No. J-204067 (March 6, 1979, Philadelphia Cty.).

The Pennsylvania Commonwealth Court, a statewide court, has recognized that state law requires the availability of adequate retardation facilities. *County of Allegheny v. Commw. Dept. of Public Welfare*, 33 Pa. Commw. Ct. 267, 269, 381 A.2d 1014, 1016 (1978). *See Hoolick v. Retreat State Hospital*, 24 Pa. Commw. Ct. 218, 354 A.2d 609 (1976), *aff'd*, 476 Pa. 317, 382 A.2d 739 (1978). A federal court has found a state statutory right to treatment or release. *Eubanks v. Clarke*, 434 F.Supp. 1022 (E.D. Pa. 1977) (*per* Chief Judge Lord).

It has long been the case that this Court accepts local law determinations by the district courts and circuit courts of appeal:

> In comparable circumstances, this Court has accepted the interpretation of state law in which the District Court and the Court of Appeals have concurred even if an examination of the state-law issue without such guidance might have justified a different conclusion.

Bishop v. Wood, 426 U.S. 341, 346 (1976) (note 10, collecting cases, omitted); *Cort v. Ash*, 422 U.S. 66, 73, n. 6 (1975) ("indeed, our practice of deference to such determinations should generally render unnecessary review of their decisions in this respect."). Sitting in their respective states and "familiar with the intricacies and trends of local law," *Hillsborough v. Cromwell*, 326 U.S. 620, 630 (1930), the views of the lower courts are accorded the greatest deference in this Court[8] and are not disturbed absent "a plain showing of error,"[9] "a definite conviction of error in the conclusion,"[10] or a decision that the lower court is "clearly wrong."[11]

Pennsylvania's Mental Health and Mental Retardation Act of 1966, 50 P.S. §§4101-4704,[12] places on the

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8. *Henderson Co. v. Thompson*, 300 U.S. 258, 266 (1937); *Reitz v. Mealey*, 314 U.S. 33, 39 (1941); *MacGregor v. State Mutual Life Assurance Co.*, 315 U.S. 280, 281 (1942); *Steele v. General Mills*, 329 U.S. 433 (1947); *Gardner v. New Jersey*, 329 U.S. 565, 575 (1947); *Estate of Speigel v. Commissioner*, 335 U.S. 701 (1949); *Propper v. Clark*, 337 U.S. 472, 486-489 (1949); *Ragan v. Merchants Transfer and Warehouse Co.*, 337 U.S. 530 (1949); *Skelly Oil Co. v. Phillips Petroleum Co.*, 339 U.S. 667, 674 (1950) ("This contention was rejected below, and we do not reexamine local law as applied by the lower courts."); *Williams v. United States*, 341 U.S. 97, 100 (1951); *Bernhardt v. Polygraphic Co.*, 350 U.S. 198, 204 (1956); *General Box Co. v. United States*, 351 U.S. 159, 165 (1956); *The Tungus v. Skovgaard*, 358 U.S. 588 (1959); *United New York and New Jersey Sandy Hook Pilots Assoc. v. Halecki*, 358 U.S. 613 (1959); *Sims v. United States*, 359 U.S. 108 (1959); *County of Allegheny v. Mashuda Co.*, 360 U.S. 185 (1959); *United States v. Durham Lumber Co.*, 363 U.S. 522 (1960); *Richards v. United States*, 369 U.S. 1 (1962); *Commissioner v. Busch's Estate*, 387 U.S. 456 (1967); *Appalachia Power Co. v. American Institute of Certified Public Accountants*, 80 S.Ct. 16 (1959) (Brennan, J., as Circuit Justice).

9. *Palmer v. Hoffman*, 318 U.S. 109, 118 (1943).

10. *Helvering v. Stuart*, 317 U.S. 154, 163 (1942).

11. *The Tungus v. Skovgaard*, 358 U.S. 588 (1959).

12. Several commitment provisions of this Act were upheld by the Court last Term in *Secretary, Department of Public Welfare v. Institutionalized Juveniles*, 95 S.Ct. 2523 (1979).

Department of Public Welfare of the Commonwealth the "duty . . . [t]o assure within the state the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them. . . ." 50 P.S. §4201(1). As the Court of Appeals observed, the statutory standard is "need" and mere confinement is impermissible:

> That language is broad and determined: The obligation is to provide services to the mentally handicapped on the basis of need. Had the Commonwealth intended to offer only confinement without more, it would hardly have spoken in terms of "adequate . . . services."

122a-123a. Both legislative history and state case law support the conclusion that the 1966 Act grants retarded people an individual determination and provision of services adequate to their needs. 123a-130a, 156a-157a; *see* cases cited *supra* at 9-10 (state court orders mandating habilitation services). This is what the lower court required. Under Pennsylvania law, county agencies and officials, including petitioners here, must establish local retardation programs, are authorized to appropriate funds for such purposes, and have both overall and particular responsibilities under an Act which "as a whole, contemplates County participation in all facets of the state's provision of services." Court of Appeals at 129a; 50 P.S. §§4301(a) and (d). As a matter of fact, the counties' liability was established for they "have joined inextricably in the state's provision — or lack of provision — of treatment." 130a.[13]

Philadelphia, Bucks, Chester, Delaware and Montgomery county officials, petitioners here, do not dispute

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13. The factual predicate for finding the county petitioners liable for "consigning the mentally retarded to inadequate living conditions," Court of Appeals at 130a, is set forth by the District Court at 41a-46a and by the Court of Appeals at 107a and 129a-130a.

the existence of the state statutory right to habilitation. This is significant as they are charged under state law with actually providing the living arrangements and educational services which comprise the process of habilitation. The county officials argue, however, that effectuation of the right, and thus its funding, is a duty of the Commonwealth, citing 50 P.S. §4201, and that a grant distribution statute, 50 P.S. §4509(5), voids local responsibility absent sufficient funding from the state.

The Court of Appeals properly rejected these stratagems, holding that "the Counties cannot at this late date escape — by pointing the finger of responsibility elsewhere — the statutory duty to provide adequate habilitation." 130a. Retardation services under state law are a "joint venture between the Commonwealth and its subdivisions," with 50 P.S. §4509(5) not absolving the county petitioners of their duty to provide habilitation but rather "delineat[ing] nothing more than the method by which insufficient funds are to be distributed." 127a.[14]

Familiar Pennsylvania law, established in the 1966 Act and recognized and applied by the state's courts, holds that "duties — such as habilitation at institutions or community living arrangements — can be imposed" on the counties and on the Commonwealth under "the intended partnership" constructed by the legislature.[15] With this independent and sufficient state law ground, one which is entirely reasonable and correct, there is no basis or need for this Court to review the judgment below by certiorari.[16]

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14. The Court of Appeals recognized in this context that "no right is without some limitations. All that section 201 promises, and all that we hold, is that to the extent Pennsylvania maintains facilities for the mentally handicapped, those facilities must provide adequate treatment or habilitation." 127a.

15. Court of Appeals Opinion at 128a.

16. Review of an independent and sufficient state law determination would be without precedent. *See* note 7 *supra*.

II. The decision below correctly holds that Congress granted retarded people a privately enforceable right to habilitation appropriate to the individual.

Beginning in 1963, Congress enacted funding legislation to aid the developmentally disabled.[17] In 1975, aware and concerned that federal funding of state programs was insufficient to guarantee the rights of the developmentally disabled, Congress enacted the Bill of Rights provision — at issue in this case — of the current statute, 42 U.S.C. §6010 of the Developmentally Disabled Assistance and Bill of Rights Act ("Act").[18]

The Court of Appeals *en banc* correctly held that the Act grants retarded people a right to habilitation, appropriate to the individual, 114a, 139a-140a, finding this right evidenced in the terms, structure and history of the Act. Judge Broderick, the trial judge, emphasized the vast differences between mental illness, for which "treatment" is deemed appropriate, and retardation, for which training and education are appropriate. 49a-50a; *see* Court of Appeals at 109a, n. 14. *See Kremens v. Bartley*, 431 U.S. 119, 135 (1977). These non-medical educational needs of the retarded are satisfied through the process called "habilitation." 109a, n. 14.

The core of the decision below — obviously correct and not in conflict with any Court of Appeals — is that the Act imposes mandatory statutory duties on Pennsyl-

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17. Mental Retardation Facilities and Community Mental Health Centers Construction Act, P.L. 88-164, 77 Stat. 282, 88th Cong. (1963); Mental Retardation Amendments of 1967, P.L. 90-170, 81 Stat. 527, 90th Cong. (1967), extended by P.L. 91-517, 84 Stat. 1316, 90th Cong., 1st Sess. (1969). The term "developmental disabilities," defined at 42 U.S.C. §6001(7), includes such conditions as retardation, cerebral palsy, epilepsy, autism and learning disabilities.

18. 42 U.S.C. §6000 *et seq.*, P.L. 94-103, 89 Stat. 502, 94th Cong., 2d Sess. (1975), amended, P.L. 95-602, 92 Stat. 2955, 95th Cong. (1978). *See* S.Rep. 94-160, 94th Cong., 1st Sess. 28-34.

vania and that these duties may be enforced by private litigants.[19]

State Duties Under the Act. Congress has the authority, not challenged by the petitioners here, to impose duties on the States by legislatively enforcing the guarantees of the Fourteenth Amendment as well as by conditioning the provision of federal funding.[20] The developmental disabilities Act has a dichotomous structure: it is both an enforcement measure *and* a funding scheme. 114a-115a. To argue, as do petitioners, that the Act is "exclusively a funding statute,"[21] is to fundamentally and unmistakably misconstrue the plain words, history and intent of the Act.

The Act is a dual purpose enactment, both a funding provision and a separate declaration of federal statutory civil rights. Subchapter III of the Act, 42 U.S.C. §§6061-6067, creates a scheme for distribution of federal funds to states with approved plans for services to persons with developmental disabilities; if this subchapter was all Congress had enacted, the Court of Appeals might have been in error. However, Congress went further and, in Subchapter I of the Act, 42 U.S.C. §§6000-6012, imposed mandatory duties on the states to afford persons with developmental disabilities their newly expressed statutory civil rights.

The Bill of Rights. With the Bill of Rights provision, §6010, Congress established certain civil rights. By

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19. The Commonwealth and the counties have received funds under the federal statute and used them for state and local community living arrangements and services. 107a, 119a, n. 20.

20. *See, e.g., Fitzpatrick v. Bitzer*, 427 U.S. 445 (1976); *Miller v. Youakim*, 440 U.S. 125 (1979) (assuming the authority under funding statute); *King v. Smith*, 392 U.S. 309 (1968); *Katzenbach v. Morgan*, 384 U.S. 641 (1966) (Section 5, Fourteenth Amendment).

21. Petition of Pennhurst State School and Hospital at 11; Petition of County Commissioners at 7.

its express terms, §6010 applies to "persons with developmental disabilities" without further eligibility requirement. By contrast, for programs funded under Subchapter III, Congress required federal approval of a state plan to meet certain habilitative standards. Unless this dichotomy, recognized by the Court of Appeals, reflects the true meaning of the Act, one would be forced to attribute to Congress the senseless intention to apply the Bill of Rights only to benevolent states already providing adequate habilitation.

This interpretation is supported by other internal features of the Act and by its legislative history:

1. In 1978, Congress supplemented the Bill of Rights, providing its own statutory commentary on §6010, stating its substance to be "rights of persons with developmental disabilities" which are "in addition to any constitutional or other rights otherwise afforded to all persons."[22] *This provision would mean nothing unless the "rights" in the Bill of Rights are rights.*

2. Under §6011(a) states must develop particular habilitation plans only where the program is funded under Subchapter III; thus, where Congress intended to link a requirement to funding provisions, it explicitly did so. The Bill of Rights, the preceding section of the Act, contains no such limitation.

3. Section 6010 itself reflects the dichotomy.[23] Six minimum standards are required for the receipt of federal or state funds under §6010(3);[24] the remaining provisions — those relied upon by the Court of Appeals — contain no such limitation.

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22. *See* H.R. Conf. Rep. 94-473, 94th Cong., 1st Sess., (1975).

23. H. Conf. Rep. 94-473 at 42, reprinted at 2 U.S. Code Cong. & Ad. News 943, 961 (1975).

24. P.L. 95-602, 92 Stat. 2955, 3007, Title V, §507 (Nov. 6, 1978).

Congress intended the Act's Bill of Rights to enforce Fourteenth Amendment protections. 117a, n. 17 (reciting legislative history).[25] Subject only to the requirement that adopted measures be "appropriate,"[26] legislation enacted pursuant to Section 5 of the amendment may impose severe restraints on state action and discretion. *E.g., Fitzpatrick v. Bitzer*, 427 U.S. 445 (1976). This Court has given great deference to Congressional findings that particular actions are appropriate exercises of Congressional enforcement authority. *See Regents of University of California v. Bakke*, 438 U.S. 265, 302, n. 41 (1979) (collecting cases). In addition, in the case at bar, Congress imposed obligations on Pennsylvania under its spending clause powers to condition federal grants on provision of adequate care. 118a-119a.

The Need for Individual Determinations Strictly Limits the Court of Appeals Decision. The Court of Appeals correctly determined that the Act provides a right to habilitation to the developmentally disabled.[27] 110a, 114a. Congress established a duty on the states to provide adequate habilitation and agreed to share in the implementation of that duty. 42 U.S.C. §§6010(3), 6061-6067.

Steering a middle course between the trial court's order to close the institution and the petitioners' pleas to be left free to confine any non-dangerous disabled person no matter how inadequately, the Court of Appeals identified a "clear preference for deinstitutionalization" in the Act, 131a, and remanded "for individual determinations by the court or the Special Master, as to the appropriateness of an improved Pennhurst for each such patient." 156a. Institutionalization was not restricted:

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25. *E.g.*, 121 Cong. Rec. 16,516 and 16,519; 121 Cong. Rec. 29,820-21; H.R. Conf. Rep. No. 94-473, 94th Cong., 1st Sess. at 42, reprinted at 2 U.S. Code & Ad. News 943, 961 (1975).

26. *McCulloch v. Maryland*, 4 Wheat. (17 U.S.) 316, 421 (1819); *Ex parte Virginia*, 100 U.S. 339, 345-346 (1880).

27. "Habilitation" is a term of art referring to non-medical education and training. *See* discussion at 7, 14 *supra*.

> For some patients, to be sure, the Act contemplates that institutionalization might be appropriate once adequate living conditions are established.

140a. The common sense principle adopted by the *en banc* court is that an individual determination for each person is needed to assure the proper conditions and setting for habilitation. 130a-140a, 156a-157a. *See* District Court Order of April 24, 1980 (placing on state and county officials duty to establish teams to make individual determinations).

The notion that structured supervised community living is the preference for the retarded, as a matter of fact, is documented in the record, inherent in the definition of habilitation[28] and in the legislation itself.[29] It is not, as petitioners extravagantly suggest, a radical mandate for uncontrolled development of unnecessary services.[30]

A Private Cause of Action is Implied Under the Act. Finding each of the *Cort v. Ash*[31] standards fully satisfied, the Court of Appeals was compelled to imply a private right of action for retarded persons under the Act. 114a-122a. The four *Cort* factors are met in this case:

> 1. *Especial beneficiaries.* No party to the litigation disputes that the retarded are among the de-

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28. *See* authorities and record references at 155a-156a.

29. *See, e.g.*, 42 U.S.C. §§6000(5) and 6010(2) and *see* discussion by Court of Appeals at 130a-140a.

30. Petition of County Commissioners at 10; Petition of Pennhurst State School and Hospital at 13. The petitioners' arguments in this regard are just so much clamjamphrie.

31. 422 U.S. 66, 78 (1975). The relevant factors in determining whether a cause of action should be implied from a federal statute are 1) whether the plaintiffs are the especial beneficiaries of the statute; 2) whether there is Congressional intent to create a private remedy; 3) whether a private remedy would further the policies of the Act; and 4) whether the cause of action is one traditionally relegated to the states. *Id.; Cannon v. University of Chicago*, 441 U.S. 677, 689, n. 9 (1979).

velopmentally disabled and thus "especial beneficiaries" of the Act. 42 U.S.C. §6001(7) (definition of developmental disabilities).

2. *Congressional intent.* Congress, recognizing that an administrative cut-off of funding would not sufficiently protect the rights of developmentally disabled individuals, made specific its intention to create a remedy in a private cause of action. The Bill of Rights section of the Act, 42 U.S.C. §6010, was added in 1975, long after the 1963 origin of the funding statute. This addition was explicitly to protect the constitutional rights recognized by the courts. *See,* S.Rep. 94-160, 94th Cong., 1st Sess. at 34. The legislative history confirms that Congress fully expected judicial enforcement of the rights enumerated in the statute, especially the right to habilitation. H.Conf. Rep. 94-473, 94th Cong., 2d Sess. at 42 ("[T]his right to appropriate treatment of developmental disability should be protected and assured by Congress *and the courts.*") (emphasis supplied); *Naughton v. Bevilaqua*, 458 F.Supp. 610, 616 (D.R.I. 1978).[32]

Congress need not expressly state that it intends a private right of action for one to be implied. *Cort v. Ash, supra*, 422 U.S. at 82. *See also, Cannon v. University of Chicago, supra*, 441 U.S. at 694. Clearly, the legislature was aware of prior litigation to enforce the right to habilitation. S.Rep. 94-160, 94th Cong., 1st Sess. at 31 (enumerating private litigation on rights of mentally retarded). It must be

---

32. In addition, Congress required the states to create a system for the protection and advocacy of the individual rights of developmentally disabled persons with the authority to pursue "legal, administrative, and other appropriate remedies" for such individuals. 42 U.S.C. §6012(a)(2)(B). With such a provision in the Act, it cannot be denied that Congress expected disabled persons, and the advocacy system on their behalf, to assert both statutory and constitutional rights in private actions.

presumed that Congress had no intention of changing the means of enforcement of the rights when it had such knowledge of precedent. *Cannon, supra*, 441 U.S. at 696.

3. *A private remedy is not inconsistent with the underlying purpose of the legislative scheme.* The legislative scheme and recognition of a private right of action are consistent with one another. It is "necessary or at least helpful" to the fulfillment of the statutory purpose. *Cannon, supra*, 441 U.S. at 703. Congress specifically reiterates its desire that the states insure the protection of the legal and human rights of the developmentally disabled citizenry and the provision of services to allow them to reach their potential. 42 U.S.C. §6000(b)(1). As is the case with other civil rights statutes, the purpose of the Act is both to avoid the use of federal funds for unconstitutional purposes and to protect individuals against the effects of such practices. *See, Cannon, supra*, 441 U.S. at 704 (Title IX); *Naughton v. Bevilaqua*, 458 F.Supp. 610, 616 (D.R.I. 1978):

> [W]ithout a private right of action to focus on and redress individual past violations and deter future ones, the guarantees promised by the Act would have little meaning. A remedial scheme that addressed only institution-wide wrongs and ignored individual wrongs would be inconsistent with Congress' central concern to correct the past neglect by large institutions of individual rights and differences in needs and potential.

4. *The cause of action is not one traditionally of state law.* A cause of action to place retarded individuals to meet their habilitative needs is not an action which is traditionally one of state law. *Naughton, supra*, 458 F.Supp. at 617. In fact, such actions have traditionally been brought in the fed-

eral courts, especially in light of the federal statutory and constitutional claims which are raised in such cases. Such actions are beyond state malpractice law. *Id.*

III. Where petitioner government officials adamantly refuse to remedy their violations of respondents' rights and where protection of state and federal statutory rights would otherwise be impossible, appointment of a master with circumscribed supervisory duties does not violate principles of federalism.

With fantastic claims of being "stripped of their sovereign power,"[33] petitioners assert that the Court of Appeals' order violates principles of federalism and must therefore be reversed. A cursory analysis of the history of the case discloses the recalcitrance of the petitioners, their refusal to remedy systemic violation of respondents' rights, and the absolute necessity of an order "tailored to cure" the offending condition. *See Milliken v. Bradley*, 418 U.S. 717, 738 (1974).

As the trial court recites, 76a-78a, after its finding of liability, the District Court provided respondents several opportunities to come forward with a plan to remedy the violations found by the court or to introduce evidence on relief and implementation. *Id.* The county defendants produced no plan and submitted no evidence. The Commonwealth defendants resubmitted a "vague and indefinite" plan the court had rejected during the trial. 78a. At no time did any petitioner indicate willingness to conform its actions to the legal standards set forth by the court. *See* 150a-151a.

Not surprisingly, given the petitioners' adamantine stance, the court found "that implementation of this Order will be impossible without the appointment of a Spe-

---

33. Petition of Pennhurst State School and Hospital at 16.

cial Master." 80a-81a. Without such an enforcement tool, the respondents would have found themselves with a paper victory, confined among the horrors of Pennhurst, without hope. The Court of Appeals expressed the need for workable relief vigorously:

> It is abundantly clear that providing the 1200 Pennhurst residents with a right to habilitation in the least restrictive environment will be a complex and lengthy process, probably involving monitoring, dispute resolution, and development of detailed enforcement mechanisms. Were we to preclude the trial court from resorting to a master, we would help make self-fulfilling the frequently made prophecy that courts are institutionally incapable of remedying wholesale violations of legally protected rights.

148 a.

The Special Master in no way supplants state and local retardation authorities. As the *en banc* Court of Appeals summarized the function, the Master "is to supervise all implementation efforts with the aid and assistance of all parties to the lawsuit. The defendants will thus have an opportunity to participate in the structuring of relief." 151a. In shaping the activities of the Special Master, the District Court has been even more limiting than the Court of Appeals' careful language; under the implementation orders of Judge Broderick, the Commonwealth and counties are given the responsibility for services to the disabled, with the Master acting as a stopgap and the court's eyes and ears. *E.g.*, Order of April 24, 1980 (pursuant to Court of Appeals' mandate, consolidating and amending all prior orders of the District Court).

In addition, because a state statute and a federal statute form the basis for the petitioners' obligation to provide habilitation, and because "[t]hese duties were known and consented to," any relevant federalism complaints are vitiated. 151a. Such complaints, in fact, are

considerably premature. A concrete disagreement raising federalism issues will not occur until a person is to be placed in a setting which is opposed by the state, counties or the person himself or herself. Such a placement will not occur without a full due process hearing, subject to challenge under the District Court's order of April 24, 1980. There is time enough in a real case to raise and consider the federalism issue.

Respondents may yet offer "a plan that promises realistically to work, and promises realistically to work now." *Green v. County School Board*, 391 U.S. 430, 439 (1968). Barring such a plan, a federal court must exercise its broad and flexible power to effectuate a remedial decree to meet the fact situation before it. *Milliken v. Bradley*, 433 U.S. 267 (1977).

Serious and life-threatening conditions were found by the lower court to be the responsibility of state welfare department and county officials. Evaluation of the needs of respondents and development of a plan for the future are clearly remedial and not punitive, *see Milliken v. Bradley*, *supra*, 433 U.S. at 288, and are imperative to implementation of respondents' rights. The record conclusively demonstrates the inability of the Commonwealth to act and the failure of the counties to provide mandated services. "Judicial authority enters only where local authority defaults."[34] See *Milliken v. Bradley*, *supra*. A more persuasive case of such local default could hardly be imagined.[35]

---

34. *Swann v. Charlotte-Mecklenburg Bd. of Education*, 402 U.S. 1, 15 (1971).

35. Respondents fail in their struggle to draw this case under the rubric of *Rizzo v. Goode*, 423 U.S. 362 (1976), and *Bell v. Wolfish*, 441 U.S. 520 (1979). In both those cases, lower courts were found to have entered orders far beyond the bounds of any cognizable rights. Here, the Court of Appeals has done nothing more than uphold a mechanism for directly implementing state and federal statutory rights, rights which, at least under state law, are not disputed by the five county petitioners. In *Rizzo* and *Bell*, unlike this case, there was no recalcitrance by government officials in hewing their actions to the limits of the law.

IV. Where a unitary plaintiff class is certified for the purpose of determining liability, and where procedural alternatives to decertification are available to resolve any possible problem, and there is no substantial conflict regarding plaintiffs' claims, there is no abuse of discretion by the Court of Appeals in declining to decertify the class.

One petitioner here, standing alone among the others, the Pennhurst Parents-Staff Association at No. 79-1489, challenges the Court of Appeals' refusal to decertify the plaintiff class on the ground that various class members' interests were antagonistic. The argument is patently friviolous and without merit. It is also an attempt to obtain review here of another judgment of the Court of Appeals regarding which no certiorari petition has been filed.

The plaintiff class includes all persons who are or may become inmates of the Pennhurst institution. As the Court of Appeals observed, their interests were common in every relevant respect:

> Plainly, the violations of federal and state law which the trial court found and which we have affirmed, are violations affecting all of the plaintiffs, not simply those who wish a transfer from Pennhurst. At the liability stage, therefore, important questions of law were common to all members of the class. Thus, regardless of any subsequent disagreement among class members as to the appropriate relief, we can think of no persuasive reason to have fractionated the class at that early juncture.

144a (citations at 145a-146a omitted). Any possible prejudice to the objecting group of Pennhurst staff and parents was eliminated by the Court of Appeals' direction to utilize "procedural alternatives, short of decertification, [which] are available to the trial court on remand in implementing individuated relief." 146a. By order of Feb-

ruary 22, 1980, the District Court did permit the Parents-Staff Association to intervene as a party plaintiff and it has participated in all implementation proceedings formally, as it previously had informally.

In *Halderman v. Pennhurst State School and Hospital*, 612 F.2d 131 (3d Cir. 1979), *not the case before this Court*, the Court of Appeals rejected the attempt of the Pennhurst Parents-Staff Association to intervene, post-judgment, in the litigation on the grounds that its interests were not properly represented. No certiorari petition regarding that judgment[36] has been filed, with the present petition serving as an ill-considered and inappropriate effort to elude its consequences.

The correctness of the decision below is further supported in that:

> 1. No persons, including parents and institutional employees, have the right to subject another to barbarous, inhumane and illegal conditions or to deny an individual determination of what services are proper. *See Parham v. J.R.*, 99 S.Ct. 2493 (1979). The Pennhurst Parents-*Staff* Association includes in its membership employees at Pennhurst and defendants in this case. The employees' union has contributed substantially to the legal representation of the group. Deposition of Edward Keller, AFSCME. This petitioner for certiorari cannot represent the inmates' interests without overwhelmingly unacceptable conflict.
>
> 2. *Hansberry v. Lee*, 311 U.S. 32 (1940), establishing the propriety of class actions, does not conflict with the Court of Appeals' decision here which recognizes, as does *Hansberry*, that class actions must include proper class representatives.

---

36. The opinion of the Court of Appeals, No. 78-1999, is reproduced as Appendix E to the Petition of Pennhurst Parents-Staff Association at 211a-217a of its appendix.

The organization of staff and parents ultimately seeks an improved Pennhurst and an opportunity to keep residents in the institution. This is the very relief ordered by the Court of Appeals. There was no abuse of discretion in the affirmance of the limited class certification and no purpose would be served by granting review on this issue.

V. There is no conflict with any decision of this Court or among the courts of appeals.

Not one of the issues sought to be reviewed involves a conflict with any decision of this Court or any Court of Appeals.[37]

A. The Pennsylvania Mental Health and Mental Retardation Act, interpreted below consistently with state and federal case law, has not been subject to any conflicting interpretation.

B. The Developmentally Disabled Assistance and Bill of Rights Act is interpreted by the court below with regard to the substantive rights of the retarded for the first time in a Court of Appeals.[38] The interpretation makes sense. It is and has been supported by the United States, a party plaintiff below, including the agency charged with the Act's enforcement.

---

37. One petitioner, the Commonwealth in No. 79-1404, alone among the others, raises as its third issue the standing of the United States to intervene as plaintiff. No decision of a court of appeals denies such a *right to intervene*. *See* note 38 *infra*. This is not a proper issue for this Court because its resolution has "no effect on the merits of the appeal." Court of Appeals at 99a.

38. In cases involving the authority of the United States to initiate litigation, as the sole plaintiff on behalf of institutionalized persons, the Fourth and Ninth Circuits held that the United States lacked authority to sue, and in *dicta*, commented on the nature of the developmental disabilities statute, but did not discuss the rights of the retarded under the Act. *United States v. Solomon*, 563 F.2d 1121 (4th Cir. 1977); *United States v. Mattson*, 600 F.2d 1295 (9th Cir. 1979).

C. No conflict is present on the questions of the scope of a federal court's remedial authority over recalcitrant litigants where implementation of its orders would be "impossible" without a master or on the question of the class certification.

VI. The Questions Presented are not appropriate for review.

While the right of retarded persons to live and learn in the community and to be free from brutal dehumanizing unnecessary confinement is undoubtedly an issue of great importance, the Questions Presented by petitioners in this case provide no opportunity for appropriate consideration by this Court.

Pennsylvania state statutory and case law is the basis for an independent and dispositive finding by the lower court of a right to habilitation. This Court has not and should not undertake to resolve the disagreement over local law between the petitioners and the lower court.

Assuming *arguendo* that petitioners' claim that the developmental disabilities Act does not create a broad right to habilitation for the retarded has some arguable validity, there can nevertheless be no doubt that in *this case*, on *this* record, numerous violations of Pennsylvania's obligations under the Act are present. It would involve this Court in rendering an impermissible advisory opinion for it to review the federal statutory question in the absence of a legitimate factual footing.

The spectre of "federalism" is one convenient for state governmental petitioners to raise. Resolution of the issue turns on the factual questions of the impossibility of implementation without strong remedial measures, the refusal of the petitioners to come forward to comply with the mandates of the law and the history of default by the responsible government officials. Such factual questions are not properly resolved by this Court.

CONCLUSION

For the above reasons, respondents Terri Lee Halderman, *et al.*, respectfully submit that the petitions for certiorari in Nos. 79-1404, 79-1408, 79-1415 and 79-1489 should be denied. Only if any of these petitions is granted should the conditional cross-petition in No. 79-1414 be granted; otherwise, it should be denied.

Respectfully submitted,

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Supreme Court, U. S.
FILED
MAY 5 1980
MICHAEL

IN THE

Supreme Court of the United States

October Term, 1979.

Nos. 79-1404, 79-1408, 79-1415, 79-1489.

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,
Petitioners,

v.

TERRI LEE HALDERMAN, et al.,
PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, et al., and
UNITED STATES OF AMERICA,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit.

BRIEF IN OPPOSITION OF PARC, et al.

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C. H. Frazier, The Menace of the Feeble-Minded in Pennsylvania (1913) (Pamph. Col., Hist. Soc. of Pa.) 14

Hearings on S. 427 and S. 458 Before the Subcommittee on the Handicapped of the Senate Committee on Labor and Public Welfare, 93 Cong., 1st Sess. 31, 32

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S. Rep. 90-725, 90th Cong., 1st Sess., 1967 U. S. Code Cong. & Ad. News, at 2062 and 2064 37

Pa. Legislative Journal (September 27, 1966) 25, 26, 27, 28

Scheerenberger, Public Residential Services for the Mentally Retarded (1976) 13

R. Smilovitz, A Brief History of Pennhurst 1908-1926, Compiled From Superintendents Documents 15

Special Message to the Congress on Mental Illness and Mental Retardation, Feb. 5, 1963, Public Papers of the Presidents, 128 (G. P. O. 1964) 23, 24

P. Tyor, Segregation or Surgery: The Mentally Retarded in America (Northwestern Univ. Ph.D. diss. 1972) 13, 14, 15

C. Vann Woodward, The Strange Career of Jim Crow (Oxford Rev. Ed. 1957) 13, 14

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IN THE

Supreme Court of the United States

October Term, 1979

Nos. 79-1404, 79-1408, 79-1415, 79-1489

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,

Petitioners

v.

TERRI LEE HALDERMAN, et al., PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, et al., and UNITED STATES OF AMERICA,

Respondents

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION OF PARC, et al.

Respondents, the Pennsylvania Association for Retarded Citizens, Jo Suzanne Moskowitz, Robert Hight, David Preusch and Charles DiNolfi, who are also conditional cross-petitioners in No. 79-1414, respectfully request that this Court deny the four petitions for writ of certiorari seeking review of the judgment and opinion of the Third Circuit in this case.

OPINIONS BELOW

The opinions of the Court of Appeals, *en banc*, not yet reported, are set forth in state and county petitioners' Joint Appendix at 89a-196a.

The opinion, judgment and orders of the District Court for the Eastern District of Pennsylvania, per Judge Raymond J. Broderick, which were before the Court of Appeals are reported at 446 F. Supp. 1295 (1977) and are set forth at 6a-88a.

JURISDICTION

The judgment of the Court of Appeals was entered on December 13, 1979. The four petitions and respondents' conditional cross-petition would invoke this Court's jurisdiction under 28 U. S. C. § 1254(1).

QUESTIONS PRESENTED

Counter-Statement of Petitioners' Questions

1. Whether the Court of Appeals' application of the Pennsylvania statute, consonant with all state court decisions construing the statute, does not support entirely and independently the judgment below.

2. Whether 42 U. S. C. § 1983 does not create a private cause of action against public defendants to enforce Section III of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U. S. C. § 6010, a law providing for the equal rights of retarded persons, independently of whether a private cause arises under § 6010 itself.

3. Whether 42 U. S. C. § 6010 does not prohibit a state which has undertaken to provide services, including residential services, to retarded people from providing

inappropriate and injurious services which defeat the developmental potential of retarded people and require that the services provided by the state be appropriate to the needs of retarded people.

4. Whether the remedies granted below, including the individual determinations, were not necessary and proper to overcome the findings made by the district court and affirmed by the Court of Appeals of defendants' violations.

5. Whether the United States was not properly permitted to intervene as a party plaintiff.

Conditional Cross-Questions

6. Whether 42 U. S. C. § 6010 prohibits further admissions to Pennhurst.

7. Whether 42 U. S. C. § 6010 prohibits the use of Pennhurst as a residence for retarded people and requires thereby that Pennhurst be phased out.

STATUTORY PROVISIONS INVOLVED

Pennsylvania's Act of October 20, 1966, is codified at Pa. Stat. Ann., Title 50, §§ 1401 *et seq.* (Purdon 1969). In pertinent part, the Pennsylvania statute provides:

> ARTICLE II. RESPONSIBILITIES OF THE STATE
>
> *§ 4201. General powers and duties of the department*
>
> The Department shall have power, and its duty shall be:
>
> (1) To assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who

need them, regardless of religion, race, color, national origin, settlement, residence, or economic or social status. 225a.

Section 111, the Bill of Rights provision, of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U. S. C. § 6010, is set forth in full at 200a-202a. In most pertinent part, § 6010 provides:

> Congress makes the following findings respecting the rights of persons with developmental disabilities:
>
> (1) Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities.
>
> (2) The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.
>
> (3) The Federal Government and the State both have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that—
>
> > (A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons; . . .
>
> * * *
>
> The rights of persons with developmental disabilities described in findings made in this section are in addition to any constitutional or other rights otherwise afforded to all persons.

STATEMENT OF THE CASE

This action began on May 30, 1974. Eight retarded people, residents of Pennhurst, and the Parents and Family Association of Pennhurst were the original plaintiffs. The United States was granted leave to intervene as a party plaintiff on January 17, 1975. Four additional retarded people, residents of Pennhurst, and the Pennsylvania Association for Retarded Citizens intervened as plaintiffs on November 12, 1975.[1]

By amended complaint, filed January 8, 1976, claims under state statute, under Section 504 of the Rehabilitation Act of 1973, 29 U. S. C. § 794 and under the newly enacted Bill of Rights provision of the Developmentally Disabled Assistance and Bill of Rights Act of 1975 were added to the original Constitutional claims under the First, Eighth, Ninth, and Fourteenth Amendments.

On November 26, 1976, the plaintiff class was certified and the several motions of defendant state and county officials to dismiss were denied. On February 4, 1977, the action was bifurcated for trial.[2] Jurisdiction arose in

1. The Pennsylvania Association for Retarded Citizens was founded in 1950 and at the time of trial had "chapters in fifty-seven of Pennsylvania's sixty-seven counties, its purpose being to advance the interest of retarded persons in Pennsylvania." 18a. Its nearly 20,000 members, most of them parents and family of retarded people and retarded people themselves, currently organized into sixty-one county chapters, "include parents, other relatives, guardians and next friends of persons residing in Pennhurst and those in jeopardy of residing there." 18a. At the time it joined this action, the Association had devoted more than two decades in the executive, legislative and other forums, recounted in the trial record, to the effort to change the conditions of Pennhurst. See *PARC v. Commonwealth*, 343 F. Supp. 279 (E. D. Pa. 1972).

2. In fact, the action was trifurcated: the first phase to be limited solely to the issue of liability, the second, to determine appropriate injunctive relief, if any, and the third to determine money damages. After trial of liability, however, the district court denied the original plaintiffs' claim for damages. 73a-75a.

the district court under 28 U. S. C. § 1343, the action being one to redress the deprivation by state and county officials of rights secured, inter alia, by 42 U. S. C. §§ 1983 and 6010 [3] and by the Constitution, as well as under 28 U. S. C. § 1331. Jurisdiction of the state law ground arose by virtue of pendent jurisdiction.[4]

After a trial of thirty-two days, from April 17, 1977 until June 13, 1977, during which Judge Raymond J. Broderick heard the testimony of eighty witnesses, of whom half were offered by plaintiffs and half by defendants,[5] and received into evidence 27 depositions of defendants and their managing agents, 108 photographs, a three-hour videotape presented by defendants, and 288 documentary exhibits, the district court on December 23, 1977 entered judgment for plaintiffs. By failing to provide such minimally adequate education, training and care as will afford a reasonable opportunity to retarded people to acquire and to maintain the life skills necessary to cope as effectively as their capacities permit, the district court held, defendants violated the constitutional and statutory rights of the retarded at Pennhurst. The Court's judgment rested alternatively upon the Equal Protection Clause and the Due Process Clause of the Fourteenth Amendment, the Eighth Amendment proscription of Cruel and Unusual Punishment, upon federal statute law, Section 504 of the Rehabilitation Act of 1973, and upon state statute.[6] On

3. See 9a, n. 2.

4. No party defendant in this case has ever sought abstention, either in the district court or before the Court of Appeals. None seek it here.

5. Plaintiffs' witnesses included three experts who had been retained by defendants to conduct a three month study of Pennhurst, eleven other experts and 26 fact witnesses, including 11 parents of Pennhurst residents and 3 retarded people who had formerly resided at Pennhurst.

6. Although the Developmentally Disabled Act ground had been raised by amended complaint, briefed on preliminary injunc-

March 17, 1978, after two hearings on remedy, the district court found state defendants' remedial plan to be "vague and indefinite," 78a, rejected it, and entered a 41 paragraph remedial order (79a-88a).

The Court of Appeals, having reheard the case *en banc* on its own motion, did not reach the constitutional grounds (108a, 131a) or Section 504 (140a).[7] Rather, concurring in the district court's extensive findings of fact (103a-108a), the Court rested its judgment upon the Developmentally Disabled Act and upon a Pennsylvania statute. The Court of Appeals *en banc* "affirmed in all respects" the judgment of the trial court "[w]ith the exception of the order to find employment for all Pennhurst employees, the order directing the eventual closing of Pennhurst, and the order banning all future admissions to Pennhurst."[8] (161a).

The Court found both in the Developmentally Disabled Act and in the state statute no ban upon large institutions as such but "a presumption in favor of placing [retarded] individuals in C[ommunity] L[iving] A[rrangement]s" (159a) and "remanded for individual determinations by the court or by the Special Master as to appropriateness of an improved Pennhurst for each such

6. (Cont'd.)
tion and specified as at issue in the pre-trial order, the district court did not rely upon it. 9a, n. 2. As of the date of the trial court opinion, that Act had been mentioned in dicta in one case, but no case had been decided on the Developmentally Disabled Act ground. Chief Judge Pettine's decision in *Naughton v. Bevilacqua*, 458 F. Supp. 610 (D. R. I. 1978) was the first holding invoking the Bill of Rights provision of the Developmentally Disabled Act.

7. Circuit Judges Gibbons, Rosenn, Weis, Garth, Higginbotham and Sloviter joined in the Court's judgment and opinion. Chief Judge Seitz, Judges Aldisert and Hunter dissented. Judge Adams did not participate.

8. The last two of the three exceptions are the subject of respondent's Conditional Cross-Petition.

patient" (156a). The standard under both statutes, the Court held, is:

> "Only where . . . an improved Pennhurst is the only appropriate place for individual patients should it be used. For all other[s], CLAs must be provided." (160a)

The dissent agreed "with the majority that the conditions at Pennhurst revealed in this record fall below a statutory or constitutional threshold of decency so as to merit judicial intervention." (162a) and otherwise concurred in the district court's findings (163a, 172a), but disagreed as to remedy.[9]

This case has been before this Court twice before. Once, before the trial below was begun, state defendants sought certiorari here to review the Court of Appeals denial of a writ of mandamus or prohibition against the district court judge to prohibit the continued participation of the United States in the action. This Court with-

9. The Pennhurst Parents-Staff Association, a petitioner here, sought to intervene in the district court after judgment and after entry of the orders. The District Court denied intervention in an opinion reported at 451 F. Supp. 233 (E. D. Pa. 1978) and the Court of Appeals *en banc* in a companion case unanimously affirmed the denial. The Court of Appeals' judgment and opinion in that case (C. A. No. 78-1999) was filed December 13, 1979 and the Pennhurst Association has not sought certiorari to review that judgment. *United Auto Workers v. Scofield*, 382 U. S. 205, 209.

The Court of Appeals granted the Pennhurst Association leave to file a brief amicus and to argue the merits of this case-in-chief, both before the panel and before the Court *en banc*, and in its opinion in this case considered and rejected their arguments on the merits. (144a-147a) On March 4, 1979, when no petition had yet been filed in this Court by state or county defendants and upon the Pennhurst Association's representation that it was uncertain whether any state or county defendant would file a petition, the Court of Appeals granted the Pennhurst Association "leave to intervene for purposes of filing a petition for certiorari to the United States Supreme Court".

out dissent denied certiorari. *Beal v. Broderick*, 431 U. S. 933 (1977). A second time, Philadelphia defendants sought a stay of certain further orders below. Mr. Justice Brennan denied the stay; Philadelphia defendants renewed the application before the entire Court; the Court requested responses to the motion from all parties, and on October 1, 1979, without dissent, denied Philadelphia's application. *Pennhurst State School and Hospital, et al. v. Terri Lee Halderman, et al.*, 100 S. Ct. 28 (1979).

SUMMARY OF ARGUMENT

Certiorari should be denied because the opinion of the Court of Appeals carefully and faithfully follows the Congressional and state legislative policy to correct the historic and continuing segregation of retarded people by finding a presumption in favor of community based facilities. Because the Bill of Rights provision of the Developmentally Disabled Assistance and Bill of Rights Act explicitly requires services to retarded persons in the least restrictive setting this case does not raise issues of constitutional interpretation or of judicial intrusion.

I. Pennhurst was created in 1913 for the express purpose of the segregation of retarded people. The lower courts found at Pennhurst, despite relatively high expenditures of money, precisely the conditions Congress has condemned—conditions of deprivation and regression, conditions of acute and chronic abuse of residents. Even the dissenting judges below had "no hesitation in agreeing that the federal judiciary should take the necessary steps to eliminate those conditions. . . ." No question of clinical treatment arises here; retarded people are not mentally ill but require education, training and care.

II. The decision below independently rested on a Pennsylvania statute enacted to "atone . . . for the wrongs we have done over the centuries", which imposes upon Pennsylvania officials the duty to provide community services to retarded Pennsylvanians. Many Pennsylvania courts have applied the Pennsylvania statute to so require and none have held, or even suggested, to the contrary. When a decision rests independently and alternatively on state grounds, this Court should follow its general policy of refusing review.

III. The Congressional enactment is a law providing for equal rights and satisfies the requirements of the several opinions in *Chapman v. Houston Welfare Rights Organization,* 441 U. S. 600 (1979) for enforcement by a private cause of action under § 1983. The Congress clearly meant the Bill of Rights provision at issue here to be judicially enforced.

IV. The Court of Appeals, applying the Congressional statute, imposed no *per se* rule. Rather, it was faithful to the Congressional mandate to end the isolation of retarded people expressed in the requirement of § 6010 that "services . . . for such disabilities . . . be provided in the setting that is least restrictive of the person's personal liberty" and be responsive to the particular needs of individual retarded people. The presumption in favor of community based facilities and the individual determination serves those ends. The extensive Congressional history makes clear that Congress was aware of, and wanted to halt, state imposed isolation of retarded people. The authorative Senate Report on the Act declared "Efforts to assure proper treatment, education and habilitation services in large institutions should not deflect attention from the fact that most of these institutions themselves are anachronisms, and that rapid steps should be taken to phase them out."

V. The orders below are appropriate to the violations of the statutes found by the lower courts and the remedies are essential to respect and satisfy the legislative decisions.

REASONS FOR DENYING THE WRIT

I. This Case Concerns Retarded People at Pennhurst, Not Mental Illness

"Careful attention," the Court has written, "must be paid to the differences between the mentally ill and mentally retarded." *Kremens v. Bartley*, 431 U. S. 119, 135-36 (1977).[10] This case concerns retarded people only and does not take the courts into "the baffling field of psychiatry." *O'Connor v. Donaldson*, 422 U. S. 575, 578 n. 2 (concurring opinion).

The court below, adopting the district court's findings (10a, 47a) wrote:

> "At the time of trial Pennhurst housed 1,230 mentally retarded individuals, some of whom also suffered from physical disabilities. The residents are not mentally ill, have broken no laws, and are not a danger to others, although, in severe cases, some are unable to care for themselves. Mental retardation is an impairment in learning capacity and adaptive behavior, and is not treatable, like mental illness, by means of drugs or psychotherapy. While the mentally retarded do suffer educational difficulties, the level of their functioning can be improved by individualized training." (104a).

Retardation is a life-long condition arising at birth or in childhood and is not subject to "cure." Retarded people achieve and maintain skills not by "treatment" or by the use of medical or psychiatric technologies, but by educa-

10. The district court judge who decided this case had dissented in *Bartley v. Kremens*. Judge Broderick's further dissent on remand was cited with approval by this Court in *Secretary of Public Welfare v. Institutionalized Juveniles*, 442 U. S. 640, 645 n. 7 (1979) *reversing*, *Institutionalized Juveniles v. Secretary of Public Welfare*, 459 F. Supp. 30, 47 (E. D. Pa.).

tion, training and care. Thus, this case is about the education, training and care of retarded citizens.[11]

The retarded people at Pennhurst were placed there at age 14 on the average and at the time of trial had been there more than 21 years on the average. PARC Ex. 48. The same figures, confinement for more than 21 years, obtain on the average for retarded people in all large public retardation institutions in the United States. Scheerenberger, *Public Residential Services for the Mentally Retarded* (1976). In contrast, the average stay of mentally ill patients at state mental hospitals is less than six months. U. S. Bureau of the Census, *1976 Survey of Institutionalized Persons* at 60.

Retardation institutions have their own peculiar history. "Pennhurst," the district court found, "was the product of [its] era" (13a)—the era of state imposed segregation. The Pennsylvania Legislature in creating Pennhurst, Act of June 12, 1913, § 1, 32 *Laws of Pennsylvania* 494 (1913), expressly declared its purpose:

> "Be it enacted, etc., that the Eastern Pennsylvania State Institution for the Feeble-Minded and Epileptic shall be devoted to the segregation . . . of epileptic, idiotic, imbecile or feeble-minded persons,"

Compare C. Vann Woodward, *The Strange Career of Jim Crow* (Oxford Rev. Ed. 1957) with P. Tyor, *Segregation*

11. As the district court wrote, "the term of art used to refer to that education, training and care required by retarded individuals to reach their maximum development" is "habilitation." 10a. Although the Court of Appeals chose to write its opinion in terms of treatment it acknowledged that the term is "strictly speaking . . . inappropriate." 109a.

As to the statutes relied upon by the court below, the Pennsylvania Mental Health and Mental Retardation Act of 1966 by its terms extends both to the retarded and the mentally ill. The federal statute, however, Section 111 of the Developmentally Disabled and Bill of Rights Act applies only to those who are developmentally disabled, which includes retarded people, but does not include the mentally ill. 42 U. S. C. section 6001(7).

or Surgery: The Mentally Retarded in America (Northwestern Univ. Ph. D. diss. 1972).[12] See also S. Rept. No.

12. *Compare,* for example, the 1913 pamphlet, *The Menace of the Feeble-Minded in Pennsylvania* (C. H. Frazier, Pamph. Col., Hist. Soc. of Pa.):

> "A comprehensive plan for the segregation of these unfortunates is perfectly feasible and economic, and if undertaken by the state, . . . [o]n state lands of no great value, far from dangerous contact with communities or easy transportation, the feeble-minded can engage in all kinds of useful occupations . . . and can render themselves self-supporting, useful and content."

and another Pennsylvanian, speaking in 1903 of the benefits of lifetime custodial service in institutions, P. Tyor, *supra* at 186:

> "they partake of the industrial and manual training given in the ante-bellum days on the plantation, which were in fact—as the world is fast acknowledging—training schools for a backward race, many of whom were feeble-minded."

with a 1900 Address to the Southern Education Association, C. Vann Woodward, *supra* at 80-81:

> "The negro race is essentially a race of peasant farmers and laborers . . . As a source of cheap labor for a warm climate he is beyond competition; everywhere else he is a foreordained failure, and as he knows this he despises his own color. Let us go back to the old rule of the South and be done forever with the frauds of an educational suffrage."

And *compare* C. Vann Woodward, *supra* at 81:

> "The conservative old Charleston *News and Courier* quoted at the beginning of this chapter as heaping ridicule upon the Jim Crow movement and the absurdity of its consequences, was of another opinion by 1906. 'The "problem" is worse now than it was ten years ago' wrote the editor. Far from being ridiculous, segregation did not now seem sufficient. Mass deportation was the remedy. 'Separation of the races is the only radical solution of the negro problem in this country. There is no room for them here,' declared the paper."

with P. Tyor, *supra* at 160-61:

> "Previously men like [Samuel Gridley] Howe believed—[that] after a few years of instruction the idiot would return to his home or parish. . . . This was why Howe did not want his school to become custodial. . . . The times, however, had changed. As Fernald [in 1903] stated: 'the Doctor wrote before the tide of immigration had set so strongly to our shores. . . . What is to be done with the feeble-minded progeny of the foreign hordes that have settled and are settling among us?' "

94-160 94th Cong. 1st Sess. (1975) at 26-27 (Title II, "Forces Behind Institutionalization and Deinstitutionalization: A History of Attitudes Toward Retardation").

The conditions of this state-imposed segregation at Pennhurst and their consequences for retarded people there have not changed materially since Pennhurst's creation. R. Smilovitz, *A Brief History of Pennhurst 1908-1926, Compiled From Superintendents Documents* (1974) [13] concluded:

> "As you read [the history] you will, if you disregard dates, discern an almost eerie similarity to [the] present situation. High costs, few staff, crowded buildings, inadequate facilities, insensitive legislators, confused contradictory labelling, inappropriate placements, delinquents, etc. are all clearly documented. You will also find the etiological base of what we today call peonage, the medical model and institutionalization."

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12. (Cont'd.)

P. Tyor, *supra* at 176, 184 also records:

> "One of the most formidable obstacles to achieving the large scale permanent segregation of mental defectives was the lack of proper institutional facilities. Despite the propaganda efforts of the superintendents and their implementation of the colony plan, there still were only accommodations for approximately one defective in ten. The superintendents likened the situation of the feeble-minded to that of the insane. They believed the numbers of each group to be equal. [The general secretary of the National Conference of Charities and Corrections and chairman of its Committee on Colonies for the Segregation of Defectives] explained [in 1899] that 'the average citizen is afraid of the insane. A few among them are so dangerous that the whole class is feared. . . . The dangers of the idiotic are less obvious.' [He] suggested that the public had to be made more conscious of the claims of the feeble-minded; when this was accomplished, the institutions would receive the appropriate degree of public consideration."

13. This history is PARC Ex. 40. The *Superintendent's Documents* record, in 1922, for example, that "the general public [is] now convinced more than ever that it is a good thing to segregate the idiot and the imbecile."

Annual Reports of the Department of Public Welfare from 1966 through 1976 show the persistence of these conditions.[14]

Recurrent legislative investigations and legislative and executive resolves changed the dollars spent at Pennhurst, the staff-resident ratios, and renewed repeatedly the effort to provide effective program there.[15] By 1977, when this case was tried, the number of retarded people at Pennhurst had been reduced to 1230 (19a); the staff-resident ratio was in excess of 1:1 (19a); the average per person per day expenditures of public funds there was $60 (44a),[16] and "on the whole, the staff at Pennhurst is dedicated and trying hard to overcome the inadequacies of the institution." (22a, 74a).

Even with all of that, the trial record showed, the District Court found and the Court of Appeals—all judges sitting, those in the majority (103a) and those in dissent (162a)—unanimously concurred in the finding that "the conditions to which Pennhurst residents have been subjected" are "abominable."

The Court of Appeals opinion recited these findings as follows:

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14. They are PARC Exhibits 41(a)-(j) in the trial record.

15. The legislative hearings and reports of 1967-68 and the various executive studies and resolves are in the trial record as PARC Exhibits 27, 28 and 42.

16. Pennsylvania's expenditures in its retardation institutions ranked it among the four highest expenditure states of the fifty. E. Butterfield, "Some Basic Changes in Residential Facilities," *President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded*, 15, 22-23 (Rev. Ed. 1976). Pennsylvania's expenditures at Pennhurst were above the average expenditures among Pennsylvania's twelve public institutions. *Compare* PARC Ex. 65 at page 86 *with* Commonwealth of Pennsylvania, Governors' Executive Budget 1979-80 at 633, indicating current per annum expenditures of over $45,000 for each resident of Pennhurst.

"[T]he environment at Pennhurst is not merely inconsistent with normalization principles but is actually hazardous to residents. [R]esidents were found to have lost skills already learned. Organized programs of appropriate education and training were found to be inadequate or unavailable. . . .

"Moreover, the Pennhurst environment was found to be unsanitary. There is often urine and excrement on the ward floors. Infectious diseases are common. Obnoxious odors and excessive noise permeate the institution. Most toilet areas do not have towels, soap or toilet paper. Injuries to residents by other residents or through self-abuse are common. Serious injuries inflicted by staff members, including sexual assaults have occurred. Physical restraints, which may be physically harmful and which have caused injuries and at least one death are resorted to more frequently than appropriate because of shortages of staff. Dangerous psychotropic drugs are used for purposes of . . . behavior control and staff convenience rather than for legitimate treatment needs. Such drug misuse produces lethargy, hypersensitivity to sunlight, inability to maintain gait, and other disabilities. Seclusion in solitary confinement has been used to punish aggressive behavior which might not have occurred if a proper regimen of training were available. Diet control is not possible because residents dine in large group eating areas without adequate staff supervision." 106a.

The dissent recited these findings as follows:

"[T]he conditions at Pennhurst revealed in this record fall below a statutory or constitutional threshold of decency so as to merit judicial intervention. The district court adequately documented the deplorable

conditions at Pennhurst . . . . Understaffing, filth, violence, enforced inactivity and other horrors make Pennhurst, in the opinion of one well-traveled expert, one of the worst institutions of its kind in the world. Under these circumstances the federal courts have the right and duty to intervene and to secure for Pennhurst's residents, at the very least, adequate living conditions. . . . I have no hesitation in agreeing that the federal judiciary should take the necessary steps to eliminate those conditions at Pennhurst." 162a-163a.

In contrast, the Court of Appeals found (105a):

"Pennsylvania operates smaller and less isolated programs referred to as Community Living Arrangements (CLAs). The latter programs reflect a recognition of the principles of normalization for the habilitation of the retarded. Under normalization principles, retarded persons are treated as much as possible like nonretarded persons. The purpose of such treatment is remediation of the delayed learning process so as to develop maximum potential in self-help, language, personal, social, educational, vocational and recreational skills. These remediation efforts, the trial court found are, in general, much more likely to succeed in smaller living units which are closer to and more reflective of the normal society." [17]

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17. At the time of trial 3,437 retarded Pennsylvanians had resided in community living arrangements. PARC Ex. 63. The CLAs are structured and supervised residences for retarded people, no larger than family-scale, located in a house or apartment in the general community and staffed by specially-trained personnel. "CLA" was not "undefined" in the court record as the state petition says, p. 6, n. 4, nor are they "*one* method", p. 9, "of caring for the retarded." PARC Exhibits 29, 30, 31, 33, 63 and 64 put before the court state defendants' own documents defining CLAs and describing in detail the full continuum of the nine different types of CLAs Pennsylvania provides.

It is not surprising that an institution with the history and purpose of Pennhurst leads to the conditions found by the courts below. This case is not about refinements of clinical method. It is about ending the abusive conditions which flow from segregation—a task with which both the Congress and courts are familiar.

II. The Decision of the State Law Ground Below Is Not in Conflict With Any Applicable State Law and Independently Supports the Judgment

The Court of Appeals' holding that retarded Pennsylvanians are entitled to adequate services which respond to their needs and to the presumption, when the state undertakes to provide residential services, that they should be placed in Community Living Arrangements is grounded alternatively and independently upon Pennsylvania statute law, the Act of October 20, 1966. (122a-130a, 157a-161a, 175a).

Notwithstanding that there may have been a federal issue of importance decided below,[18] since the decision below is predicated independently on state law grounds and since that decision was in no way inconsistent with applicable state law, certiorari should not be granted. To review the federal issue would be futile: the Court's power is to "correct wrong judgments, not to revise opinions." *Herb v. Pitcairn*, 324 U. S. 117, 125 (1944); *Fox Film Corp. v. Muller*, 296 U. S. 207 (1935). To review the state law issue is contrary to the Court's "general policy [to] leave undisturbed [a] Court of Appeals' holding on a question of state law." *Spiegel's Estate v. C. I. R.*, 335 U. S. 701, 708 (1949); *Huddleston v. Dwyer*, 322 U. S. 223, 237 (1944).

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18. There is no conflict among the Circuits on any issue presented by this case.

The four petitions here make no showing that the decision below is in any way in conflict with applicable state law; indeed the petitions attempt no such showing, offering no citation to any state decision even arguably in conflict. To the contrary, the decision is entirely consonant with the Pennsylvania statute and with its construction and application in an unbroken line of state court decisions. Had it decided the state law question any way other than it did, the Court of Appeals would have erred.

1. On the basis of the Pennsylvania statute, § 4201 in particular, nearly two score state trial courts have denied commitments to institutions and ordered the provision of community residential services for retarded people. In one of these cases, for example, *In Re Joyce Z.*, 4 Pa. D. & C. 3d 596 (C. P. Allegh. Co. 1975) Judge Cohill, then in his tenth year as judge of Allegheny County Family Court, now a judge of the United States District Court for the Western District of Pennsylvania, held that the statute barred an institutional commitment as unsuitable and required the provision to a 14 year old profoundly retarded girl of casework services, placement in a foster home and certain services for her physical disabilities. This decision and six other such Pennsylvania trial court decisions are noted and described in *Coval et al.*, "Rules and Tactics in Institutionalization Proceedings for Mentally Retarded Persons," 12 *Education and Training of the Mentally Retarded* 177, 180-82 (A Journal of the Division on Mental Retardation, Council for Exceptional Children, 1977). Thirteen of these cases were before the court below in an Appendix filed August 15, 1979.

2. State petitioners incorrectly say in their petition (p. 16) that what they characterize as "this limited holding" of the Court of Appeals—"that . . . Pennsylvania . . .

facilities for the mentally handicapped . . . must provide adequate . . . habilitation"—"is not supported by any decision of any court of state-wide jurisdiction." To the contrary, in *In Re Guzan,* — Pa. Comwlth. Ct. —, —, 405 A. 2d 1036, 1038 (1979), the Commonwealth Court of Pennsylvania, the intermediate appeals court in such matters, considered the question of state law and, citing and quoting the federal district court opinion in this case with approval, held "that when the state . . . commits retarded persons it must provide 'minimally adequate habilitation'." In fact in that case, which concerns transfers between Pennsylvania facilities, following a Pennsylvania Supreme Court decision construing the statute [19] and citing and quoting with approval the district court opinion in this case, the Commonwealth Court held:

> "Because the Commonwealth maintains facilities of varying degrees of restriction (. . . state facilities are 'maximum' restrictive facilities and local facilities are considered 'minimum' facilities) the hearing requirement articulated in *Eubanks* [v. Clarke, 434 F. Supp. 1022 (E. D. Pa. 1977)] for the mentally ill applies with even greater force to the mentally retarded: 'individuals who have not broken any laws, . . . and who are not in any way a danger to society.' *Halderman, supra,* 446 F. Supp. at 1313."

Among the other state appellate court decisions construing the statute which make clear at the least, that the highest state court would probably rule as the Court of Appeals did and that the decision below was not clearly wrong,

19. In that case *Com. ex rel. DiEmilio v. Shovlin,* 449 Pa. 177, 181 n. 7, 295 A. 2d 320, 323 n. 7 (1972) the Pennsylvania Supreme Court articulated the § 4416(d) standard for transfers to more restrictive facilities in terms similar to the presumption the Court of Appeals found in the statute in this case—"that his illness could be beneficially treated only at a maximum security institution."

see *County of Allegheny v. Commonwealth Department of Public Welfare,* 33 Pa. Commw. Ct. 267, 381 A. 2d 1014, 1016 (1978) (citing *Joyce Z.* with approval); *Com. ex rel. DiEmilio v. Shovlin,* 449 Pa. 177, 295 A. 2d 320 (1972).[20]

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20. *Hoolick v. Retreat State Hospital,* 24 Pa. Commw. Ct. 218, 223-24, 354 A. 2d 609, 611-12 *aff'd mem.* 496 Pa. 317, 382 A. 2d 739 (1978) is not to the contrary and was seriously misread in the dissent below (176a). In *Hoolick,* the converse of this case, where plaintiffs and their union counsel sought to *stop* the state from *closing* Retreat and transferring residents to other Pennsylvania facilities, the Commonwealth Court held that the statute does *not* require that a particular, *institutional* facility must remain open. This decision is consistent with the decision below, and, if pertinent at all, tends to support it. The Commonwealth Court said:

> "Nor are we persuaded that the provisions of Section [4] 202 of the Act directing the State to operate State facilities and authorizing the establishment of additional facilities, either specifically or inferentially, require the State to continue to operate forever all State mental health facilities functioning at the time of passage of the Act. . . . Its implementation and need for flexibility to meet improved or new methods and means of treatment would be seriously impaired if not totally frustrated if Retreat or any other particular State mental health facility were to enjoy such a monolithic status."

Compare 176a-177a.

Similarly, the dissent misreads *County of Allegheny v. DPW, supra* (177a). The Commonwealth Court there approved *Joyce Z.*, including its holding that the Commonwealth is obliged to pay for residential care, and decided with perfect consistency, only that the cost is subject to a reasonable cost limitation. There was no assertion in *Allegheny* that the cost limitation rendered impossible the provision of adequate care or was otherwise unreasonable. As to *In Re Wayne K.*, 34 Pa. Commw. Ct. 10, 382 A. 2d 989 (1978), see note 2 of the decision, 382 A. 2d at 991, showing that the private residential service provided was to be state reimbursed under a statutory 90% formula, albeit not 100% as under a nonapplicable statutory formula. These two cases concern the proper allocation of service costs as between state and county under statutory formulae. They do not concern the service rights of retarded people. The decision of the Court of Appeals below did not purport to disturb the statutory allocation formulae, nor does it. However the costs are to be shared, the Court holds only that retarded Pennsylvanians are entitled to adequate services.

3. Other decisions construing the state statute by federal courts sitting in Pennsylvania, "judges . . . who are familiar with the intricacies and trends of local law and practice," *Huddleston v. Dwyer, supra,* 322 U. S. at 1018, are in accord with the decision below.[21] In *Eubanks v. Clarke,* 434 F. Supp. 1022, 1026-27 (E. D. Pa. 1977), for example, Chief Judge Lord held that Section 4201 establishes a state law right to "treatment."

4. The state statute itself, its origin and its legislative history fully support its reading by the decision below. The key provision of the 1966 Act says:

> "§ 4201. General Powers and Duties of the Department.
>
> The department [of public welfare] shall have the power, and its duty shall be:
>
> (1) to assure within the State the availability and equitable provision of adequate . . . mental retardation services for all persons who need them, regardless of religion, race, color, national origin, settlement, residence or economic or social status."

The 1966 Act was adopted unanimously by both Houses of the Pennsylvania General Assembly in a special session called to consider it. The 1966 Act was among the first state statutes enacted in response to the Kennedy initiatives. In his special message to the Congress, February 5, 1963, *Public Papers of the Presidents* 128, 137

21. Among the six judges who made the decision of the Court of Appeals below four are Pennsylvania lawyers, one had served as Secretary of the Department of Public Welfare of the Commonwealth, another as a member of the Allegheny County MH-MR Board. The District Court Judge, a Pennsylvania lawyer, had served as Lieutenant Governor of the Commonwealth.

(1964), 109 *Cong. Rec. 1837*, President Kennedy had said:

> "[T]here is . . . a desperate need for community facilities and services for the mentally retarded. We must move from the outmoded use of distant custodial institutions to the concept of community-centered agencies. For those retarded children or adults who cannot be maintained at home by their own families, a new pattern of institutional services is needed. [S]ervices to the mentally retarded must be community based." 109 *Cong. Rec.* 1841, 1838.

The message called upon the Congress:

> "To bestow the full benefits of our society on those who suffer from mental disabilities; . . .
>
> "To provide for early diagnosis and continuous and comprehensive care, in the community, of those suffering from these disorders;
>
> "To stimulate improvements in the level of care given the mentally disabled in our state and private institutions, and to reorient those programs to a community-centered approach;
>
> "To reduce, over a number of years, and by hundreds of thousands, the persons confined to these institutions.
>
> "To retain in and return to the community the . . . mentally retarded, and there to restore and revitalize their lives through better health programs and strengthened educational and rehabilitation services; and
>
> "To reinforce the will and capacity of our communities to meet these problems in order that the

> communities, in turn, can reinforce the will and capacity of individuals and individual families." 109 *Cong. Rec.* 1842.

In the fall of 1963, Congress enacted the Mental Retardation Facilities Construction Act, P. L. 88-164, 72 Stat. 282,[22] and the Maternal and Child Health and Mental Retardation Planning Amendments of 1963, P. L. 88-156, 77 Stat. 273. The Pennsylvania Act followed.

The prime sponsor of Pennsylvania's 1966 Act, Senator Pechan, was clear in presenting the Act to the House in which the Act originated, what the evil was that the Act was intended to overcome:

> "It atones . . . for the wrongs we have done, over the centuries, to our fellowmen upon whom the misfortune of . . . retardation has fallen. We have labeled them . . . feeble-minded. Because their disability was unseen, we have had little sympathy with it. . . . We have locked them up, put bars on their cells, and strait jackets on their bodies. We have exiled and sometimes forgotten them. We have sometimes cut them off from human society, and abandoned them to their distress and misery."

Pa. Legislative Journal, p. 76 (September 27, 1966) (pp. A1-2 in Appendix A to this Brief). Its purpose was also clear:

> "The object of this legislation is to make it possible for every mentally disabled person to receive the kind of treatment he needs, when and where he needs it. It will make those services available to every citizen in every community which are now

22. This Act is the direct lineal progenitor of the Developmentally Disabled Assistance and Bill of Rights Act of 1975.

> available only to a lucky few in the more progressive communities." Id. at 76 (A2).[23]

Thereupon, Senator Pechan listed in common language some of the community services which were to be provided.[24]

> "It will open more beds in the local general hospitals. It will make available the services of psychiatrists and psychologists, of psychiatric nurses and social workers, of specially trained occupational therapists, of speech and hearing therapists, of activities directors and of child care workers. It will supplement the benefits of therapy with daytime and evening programs of activity. . . . It will provide productive activity for those who can work only in a sheltered situation, and for those who are able, it will prepare them to go back to the customary world of business and industry, or to go forth into it for the first time, at the case may be. For those in acute distress service will be available twenty-four hours a day, and the violent will find protective care instead of the harsh custody of jail."

Although the statute and its legislative history contemplate that institutions may continue to exist, as the decision below held, the statute and the legislative his-

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23. The legislative history thus resolves whatever ambiguity, see state petition at p. 16, might otherwise be thought to attach to the statute's mandate "to assure within the State the *availability* and *equitable* provision of adequate . . . retardation services to all who need them" (petitions' emphasis). Those words were intended not to trim or to limit the right to community services but to assure provision of the needed services *in every community*.

24. These services in the community, he said, "will re-create and strengthen the ties which bind one human being to another and make us comfortable in each others' company." *Id.* at 76 (A2).

tory, the latter in language quite like the Court of Appeals' articulation of the presumption for community living arrangements, show a decided preference for community services:

> "There will be those who will need a long stay in an institution, some even for whom this is the necessary and the only kind of provision for the rest of their lives. We are not about to close our State schools and hospitals or our State mental hospitals. The great point is that we shall know that the treatment program of one of these institutions is the indicated treatment before the patient leaves his community. Diagnosis and evaluation of his condition will precede the disposition of his case, *and everything possible will be done for him in his hometown.*" Id. at 76 (A2-3) (emphasis supplied).

Nor were those in institutions to be abandoned there:

> "If he responds to the program of the institution and the time comes when he is ready to return home, he will not be turned out into the cold. These same community services will be there to help ease the transition back to normal life. Nobody will be lost from sight. Care will be continuous, even though the patient may move from in-patient to out-patient care, from hospital to workshop, from halfway house to foster home." Id. at 76 (A3).

The legislature recognized that "these community services, which must be made available in every community," were not yet there and understood the Act to affirmatively require "the new ones to be created where they are lacking." Id. at 76 (A3, A4).

The 1966 Act, entitled by the legislature "the Mental Health and Mental Retardation Act of 1966," could just as well have been entitled the Pennsylvania Community Services Act.[25]

5. No party defendants sought absention in either of the courts below; none made even any suggestion of absention below. None of the four petitions in this Court raise any question of absention. There is no question here but that pendent jurisdiction was properly invoked and exercised below, *United Mine Workers v. Gibbs*, 388 U. S. 715 (1966) and the state law ground properly decided, *Hagans v. Levine*, 415 U. S. 528, 543 (1974), *Ashwander v. TVA*, 297 U. S. 288, 341 (1936), *Siler v. Louisville & Nashville R.R. Co.*, 213 U. S. 175, 193 (1909).

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25. Unaccountably, the dissent below says:

> "I believe it would be anomalous to attribute to the General Assembly of 1966 an intention to require treatment of the mentally retarded in a community setting because it would be less restrictive than an institution when the state did not even consider community treatment until 1970." (176a).

The dissent overlooks the plain language of the 1966 Act and its piercing clear legislative history. The pages of the Legislative Journal which apart from the tally of votes constitute the legislative history of the 1966 Act were before the Court of Appeals in an Appendix, filed July 26, 1979 and they are attached to this Brief as Appendix A.

The dissent's reference to 1970 is to the Act of November 27, 1970 appropriating $21 million:

> "to provide definite treatment and normalizing accommodations for mentally retarded residents of Bucks, Chester, Delaware, Montgomery and Philadelphia Counties and to be located in the same counties. The units are to provide accommodations for approximately 900 patients [now resident] at Pennhurst [and] to provide logical dispersal and reorientation into the community for [these] Pennhurst residents and alternatives to institutionalization for the Pennhurst waiting list population and other mentally retarded citizens of the area who require such treatment and accommodations."

The district court found that $18 million of this $21 million for community services have yet to be spent and only 37 Pennhurst residents have benefited from the appropriation." (44a).

III. Enforcement of 42 U. S. C. § 6010 in a Private Cause of Action Raises No Issue, Either Under § 1983 or Under § 6010 Itself, Meriting Review by the Court

This is a § 1983 case; § 6010 is a law providing for equal rights. Thus under § 1983, even apart from directly under § 6010 itself, a private cause of action lies to enforce 42 U. S. C. § 6010. As to a private cause of action, no question meriting review by the Court is presented by the petitions.

1. This case does not raise any implied private cause of action question like those which the Court has recently addressed in *Cannon v. University of Chicago*, 441 U. S. 677 (1979). Although the Court there found an implied private cause of action under Title IX, the question arose only because the defendants in that case were private parties. *Id.* at 680 n. 2, 696 n. 21, 700 n. 27 (Ct. op.), 719, 723 (concurring opinion). In this case, the defendants are public officials acting under color of state law and it is state action and their official conduct which is at issue. In such a case § 1983 expressly creates the cause of action and the right of private parties to enforce a § 1983 cause of action is unexceptional. The only necessary inquiry is whether the cause involves "the deprivation of any rights, privileges, or immunities secured by the Constitution and laws"—in this case, whether the Bill of Rights provision of the Developmentally Disabled Assistance and Bill of Rights Act is within the ambit of § 1983.

2. Although Learned Hand would have found that all statutes of the United States are "laws" within the meaning of § 1983, *Bomar v. Keyes*, 162 F. 2d 136 (2d Cir. 1947), and Mr. Justice White would also, *Chapman v. Houston Welfare Rights Organization*, 441 U. S. 600, 646 (1979) (concurring in judgment), it is not necessary here as the Court found it was not in *Chapman*, *id.* at 616,

623, to reach that question. It is uncontroverted that at the least statutes of the United States providing for equal rights are "laws" within § 1983. *Id.* at 623 (concurring opinion).[26] Section 6010 is such a statute.

3. The court below held that the Bill of Rights provision is a statute enacted pursuant to the Congress' power to enforce the Fourteenth Amendment (117a-118a). *Katzenbach v. Morgan*, 384 U. S. 641 (1966); *Fitzpatrick v. Bitzer*, 427 U. S. 445 (1976). Its legislative history shows that in enacting 42 U. S. C. § 6010 what the Congress was about was "legislation providing for equality in the enjoyment of civil rights." *Chapman v. Houston Welfare Rights Organization, supra* at 633 n. 14 (concurring opinion). In S. Rep. 94-160, 94th Cong., 1st Sess. (1975), the United States Senate Labor and Public Welfare Committee, which originated the Bill of Rights provision, wrote of the provision:

> "The Committee is firmly convinced that Congress must take action to ensure the humane care, treatment, habilitation and protection of the mentally retarded. The Federal Government has the responsibility to provide equal protection under the law to all citizens." S. Rep. 94-160 at 32.

See also H. Rep. 95-1188, 95th Cong., 2nd Sess. at 7 (1978) with regard to the 1978 Amendment ("the committee recognized the need for legislation which would insure . . . equitable access to all benefits which are the right of citizens of the United States.") Introducing floor con-

26. The Opinion of the Court in *Chapman*, 441 U. S. at 611 said:

> "the prime focus of Congress in all of the relevant legislation was ensuring a right of action to enforce the protections of the Fourteenth Amendment and the federal laws enacted pursuant thereto."

sideration of the bill, the primary sponsor of the Bill of Rights provision, Senator Javits said:

> Congress should reaffirm its belief in equal rights for all citizens—including the developmentally disabled. Congress should provide the leadership to change the tragic warehousing of human beings that has been the product of insensitive federal support of facilities providing inhumane care and treatment of the mentally retarded. The Bill of Rights . . . represents this new direction, and begins this reaffirmation." 121 Cong. Rec. 16519 (1975).

See also the remarks of Senator Randolph, 121 Cong. Rec. 16515; of Senator Stafford, 121 Cong. Rec. 16516; of Representative Young calling the bill to the House floor, 121 Cong. Rec. 9965; and of Representative Badillo, 121 Cong. Rec. 9978. Testimony and deliberations during the two years of hearings by the Senate Committee on Labor and Public Welfare prior to its enactment show the Congress' consciousness that it was the Constitution and the equal rights of retarded people which the Congress was enforcing.[27] *Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973: Hearings on S. 427 and S. 458 Before the Subcommittee on the Handicapped of the Senate Committee on Labor and Public Welfare*, 93 Cong.,

27. This Court held in *O'Connor v. Donaldson*, 422 U. S. 567, 576 (1975) that:

> "a state cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom with the help of willing and responsible family members or friends."

This statute, § 6010, is fairly read to require state and federal governments both to be that friend of retarded citizens. The freedom whose "equality in the enjoyment" the Congress sought to enforce includes the freedom of association, the freedom of expression, the freedom to learn, develop and grow, the freedom of family integrity and the freedom to enjoy personal security.

1st Sess.; *Developmentally Disabled Assistance and Bill of Rights Act, 1974: Hearings on S. 3378 Before the Subcommittee on the Handicapped of the Senate Committee on Labor and Public Welfare,* 93 Cong., 2nd Sess.; *Developmentally Disabled Assistance and Bill of Rights Act, 1975: Hearings on S. 462 and S. 1194 Before the Subcommittee on the Handicapped of the Senate Committee on Labor and Public Welfare,* 94th Cong., 1st Sess.

4. Should the Court chose to reach the question whether an implied private cause of action arises directly under § 6010, the standards applied in *Cannon, supra,* suggest that it does.[28] Section 6010 on its face seems to say so, even though it does not use the particular words private cause of action, by explicitly associating the set of rights which it creates with other rights which are privately enforceable, as well as by the very use of the word "rights":

> "The rights of persons with developmental disabilities described in findings made in this section are *in addition to* any constitutional or other rights afforded to all persons." (emphasis supplied)

The legislative history of § 6010 is explicit that Congress intended that it be judicially enforceable. In 1975, the Chairman of the Senate Labor and Public Welfare Committee which originated the Bill of Rights provision, said:

> "Over the past few years, the horrifying conditions which exist in most of the public residential institutions for the mentally retarded and other developmentally disabled persons have provided shocking testimony to the inhuman way we care for such

28. Only one other court has decided the question under § 6010 itself, see *Naughton v. Bevilacqua,* 485 F. Supp. 610 (D. R. I. 1978) (accord).

persons. The conditions at Willowbrook, at Partlow in Alabama, and at Rosewood in Maryland, and at many other institutions have shown beyond a shadow of a doubt that the treatment of these individuals is worse then all of us would like to admit.

"Steps to scale down many of these large custodial institutions have resulted in no-so-large institutions, often with not much improved care and with little follow-up. This has been true at Willowbrook: in 1965 and again in 1972, broad criticism has been levied at this institution; all indications point toward little change, unless substantial legal and advocacy pressure is forthcoming.

* * *

"S. 462 provides a framework by which the constitutional rights of residents and other persons with developmental disabilities may be enforced." 121 Cong. Rec. 16516-7.

In 1978, when § 6010 was amended to include the sentence recited above, the Chairman of the Judiciary Committee, speaking on the floor of the Senate, said:

"I do not know how many times we have had television documentaries on Willowbrook and Forest Haven, and other institutions in this Nation and still nothing gets done. The public looks at these various programs and they absolutely deplore the conditions that, in too many instances, have been the lot of people that are covered by this legislation.

"Everyone in here knows that the only way that change is going to be brought about is the long, difficult, persistent, and dedicated advocacy . . . through challenges in the courts, for the kinds of rights which

are being guaranteed in this legislation. That is the way it is done." 124 Cong. Rec. S. 15663 (daily ed. Sept. 21, 1978).

On all other counts as well § 6010 satisfies *Cannon*, as the alternative analysis of the court below (114a-116a, 118a-120a) shows, and with which the dissent did not disagree (164a).

IV. The Court of Appeals' Faithful Application of § 6010 Raises No Issue Meriting Review by the Court

The federal claim here is statutory. The court below rested entirely upon the statute, § 6010, when it held that retarded people are entitled to services appropriate to their needs, that the Congess had expressed a preference for providing services in settings least restrictive of their personal liberties, that there is a presumption in favor of community settings to be applied in making individual determinations. This is not a constitutional case.[29] The arguments petitions make to this Court might be in point if it were a constitutional case but the Congress in § 6010 has already resolved the policy matters.[30] The only question possible here is whether the court below accurately and sensitively interpreted this "relatively new and innovative legislation" (162a). As to that, the decision below is unmistakably faithful to the Congressional enactment.[31]

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29. Of course, if this Court were to reject § 6010 and the Pennsylvania statute as adequate grounds for the Circuit Court's judgment, the constitutional issues and § 504 statutory issue raised in the district court would have to be decided.

30. As the Court put it in a similar context in *Cannon v. University of Chicago:*

> "In short, [petitioners'] principal contention is not a legal argument at all; it addresses a policy issue that Congress has already resolved." 99 S. Ct. at 1964.

31. Unlike *O'Connor v. Donaldson*, 422 U. S. 563 (1975); *Wyatt v. Aderholdt*, 503 F. 2d 1305 (5th Cir. 1974); *Burnham v.*

1. Petitions and the dissent misstate the reach of the court's opinion below. They say the court ignored Congress' desire to establish community care as the goal, but not as an inflexible requirement, an "absolute obligation" (168a) which is "rigid[ly] appli[ed]" (188a). To the contrary, by recognizing only a presumption for community services and carefully requiring individual need determinations the court below clearly meets and reflects Congress' attempt to move seriously in a particular direction without imposing a harsh and arbitrary rule.

Although it approved Judge Broderick's findings that "in general institutions are less effective than community living arrangements in facilitating the right to habilitation in the least restrictive setting" and that "for the retarded class members as a whole, Pennhurst cannot be an appropriate setting in which to provide habilitation" (155a-156a), and recognized that the Congress had reached the same conclusion in the Act, the court below insisted, based upon the Act, upon a "canvass" of the discrete needs of individual residents and "individual determinations" (156a). "The framers", the court wrote,

> "did not anticipate a shutdown of all institutions when they endorsed a right to habilitation in the least restrictive environment. Rather, they recognized that for some persons institutions, once improved, might be appropriate." (157a).

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31. (Cont'd.)

Georgia Department of Public Health, 503 F. 2d 1319 (5th Cir. 1974), *cert. denied* 422 U. S. 1057 (1974); *New York Association for Retarded Citizens v. Rockefeller*, 393 F. Supp. 715 (E. D. N. Y. 1975) this is the first case in which a federal statutory ground for the application of federal standards to state mental retardation facilities was presented. Consequently, the decision of the court below is not expressive of its own views on "normalization" or its own fashioning of legal rules from "a mass of social science . . . data" (162a) but constitutes adherence to Congressional policy.

"It is plain", the court wrote, "that no *per se* rule against institutions was contemplated" (157a), and the court established none: "We have recognized that although institutionalization is strongly disfavored, it is not foreclosed completely by governing federal and state statutes." (159a). By directing that "on remand, the court or the Master should engage a presumption in favor of placing individuals in CLAs" and that "in the process . . . the special needs and desires of individual patients must not be neglected" (159a), the court surely did not mandate any "rigid application" (188a) of the Congressional statutory requirements but rather ordered what the statute and its legislative history makes inescapable.[32]

2. Section 6010 was enacted in 1975 and amended in 1978.[33] On its face it means just what the court below held it means:

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32. It is incorrect to say as the state petition, pp. 12, 13, and the Pennhurst Association petition, p. 16, do—and as did the dissent (163a)—that the court below has required placement in community facilities "regardless of the feasibility or practicality of such a course of action."

The record showed and the courts below found that at the time of trial 3,437 retarded Pennsylvanians had been served in structured and supervised community facilities, including people profoundly retarded with multiple handicaps, (105a, PARC Ex. 63, 42a) and including some (105a, 28a n. 32) who had been transferred to community facilities from Pennhurst. As the dissent acknowledges "given proper facilities, all of [Pennhurst's residents] could be served in the community" (173a).

The record also showed and the courts below found that the cost of services in community facilities is, per person, less than the cost of Pennhurst (105a, 160a, n. 39, 44a). During the three years of hearings from which § 6010 was formulated, the Congress heard the same facts about relative costs. Hearings, *supra*.

33. The Developmentally Disabled Assistance and Bill of Rights Act contains two distinct kinds of provisions: (1) program assistance provisions and (2) the rights provision, now § 6010. As the Chairman of the Senate Committee said on the floor:

> "S. 462 provides a framework by which the constitutional right of residents and other persons with developmental disabilities

"§ 6010. Congressional findings respecting rights of developmentally disabled

Congress makes the following findings respecting the rights of persons with developmental disabilities:

(1) Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities.

(2) The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.

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33. (Cont'd.)
may be enforced. *Title I* assists states in their planning towards the provision of services to meet the needs of developmentally disabled individuals. *Title II* of the Legislation sets forth basic minimum standards for both community agencies and facilities and residential facilities. . . .

"*Title II* of the bill sets forth a means to assure that the rights of developmentally disabled individuals will be protected." 121 Cong. Rec. 16517.

The program assistance provisions of the Act are the most recent in the line of community program assistance incentives following the 1963 Kennedy enactment, which had been augmented in 1965, P. L. 89-105; in 1967, P. L. 90-170 (see S. Rep. 90-725, 90th Cong. 1st Sess., 1967 U. S. Code Cong. & Ad. News, at 2062 and 2064); and in 1970, P. L. 91-517 (the first "DD" Act, the Developmentally Disabilities Services and Facilities Construction Act").

The 1975 Act was the first to contain a rights provision, reflecting the Congressional judgment that "encouragement" by program "incentives" were not by themselves enough to achieve Congress' purpose and that judicially enforceable rights needed to be added thereto. It may be correct to say, as the petitions do, that requirements stated in the program provisions run only to programs receiving funds under those provisions, but the requirements of 6010(3)(A) run with all public funds.

It is the rights provision that is at issue here, and although the history of the program provisions may, like the history of other related enactments, inform the meaning of the rights provision, any limitations in the program provisions cannot be imported into the rights provision unless the language of § 6010 itself and its own particular legislative history so require.

> (3) The Federal Government and the State both have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that—
>
> (A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons; . . . .
>
> ° ° °
>
> The rights of persons with developmental disabilities described in findings made in this section are in addition to any constitutional or other rights otherwise afforded to all persons."

The language is plain enough. One way to analyze it is as follows. Section 6010(1),[34] in requiring "appropriate . . . services and habilitation for such disabilities", and § 6010(3)(A),[35] in requiring "services and habilitation appropriate to the needs of such persons," raise the question what the Congress meant by appropriate. On its face it meant that the services must respond to individual needs, as the court held. And on its face § 6010(2) may fairly be taken to say that to be individually appropriate the services must "be designed to maximize the developmental potential of the person" and be "provided in the setting that is least restrictive of the person's personal liberty." [36]

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34. Section 6010(1), like § 6010(2) runs to all people with developmental disabilities.

35. Section 6010(3)(A) runs to people with developmental disabilities who are in any "institutional or other residential program" which receives "public funds," not just DD Act program funds. Even so, the Philadelphia petition, p. 7, is not correct in saying that it receives no DD program funds. The trial record, e.g. PARC Ex. 58, showed that Philadelphia received nearly $1,000,000 in DD funds.

36. Neither the Congress nor the courts below contemplated that a "setting least restrictive of . . . personal liberties" means

Such is precisely what the court below held and structured relief to achieve. It is what the legislative history shows the Congress had concluded is necessary for retarded people in order to be as fully equal citizens as they are able. It is what Congress legislated to provide. It is what the record shows, as Congress would have expected, is wanting at Pennhurst, most unlikely to be achieved there but very likely available in community facilities. Thus in ordering individual determinations and articulating the rules which guide them, the court below did no more than the Congress required.

3. The Section of S. Rep. 94-160 at pp. 26-34, entitled "Forces Behind Institutionalization and Deinstitutionalization," summarizes the conclusions from two years of hearings and tells what the Congress was doing in the Bill of Rights provision and why.[37] The Congress acted

36. (Cont'd.)
only, or even very importantly, an "unfettered freedom" (91a) to come and go, to move about, at will.

They knew that the beneficiaries of the statute included many retarded people who need structured and supervised residential services. All retarded persons require, as to some degree does every person, the help of friends to survive safely in freedom. A residential setting "least restrictive of . . . personal liberties" is not less important thereby, but more important. The personal liberties at stake are the full range of freedoms which may be broadly stifled, as *Shelton v. Tucker,* 364 U. S. 487, 488 put it, by life in an isolated institution: liberty of association, of expression, of the right to learn, of family integrity and of the right of personal security. Their infringement at Pennhurst as the record shows is not a mere formal violation of liberty rights, but a defeat of the citizens' very capabilities. We do not construct and guarantee liberties just for the sake of having them but because having them is a fundamental to human growth—for retarded people as for others.

37. As originally formulated the Bill of Rights provision ran to approximately 400 pages specifying service standards in great detail. Ultimately the Congress eschewed such an approach in favor of the succinct articulation of the basic rights that is § 6010. H. R. Conf. Rep. 94-473, 94th Cong. 1st Sess. 42-45; 1975 U. S. Code Cong. & Ad. News 961-63.

to remedy "the rejection and exclusion from the mainstream of society" of retarded people. *Id.* at 27. Congress sought a middle way between warehousing and dumping. It recognized that even a fixed-up and improved institution will not provide a decent or adequate environment for habilitation.[38] Nonetheless, the Congress understood that there might be some few who required an improved institution.[39] But they were clear that it was few. The key Congressional finding, which must inform the reading of § 6010, was:

> "It must be recognized that the vast majority of developmentally disabled persons and the vast majority of persons now institutionalized should not be in these

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38. For example, S. Rep. 94-160 at 33:

> "The Committee feels that the standards set forth in Title II are minimum standards to insure basic human dignity where institutional care . . . is found. It is *not*, however, the Committee intent that enactment of this Title should be construed *in any way* to constitute support of institutionalization of the mentally retarded." (emphasis supplied).

Of the "institution or residence" standards in § 6010(3)(*B*)(*i-vi*), the Conference Committee Report said:

> "[We] recognize that the six minimum standards are designed to protect the basic human needs of developmentally disabled individuals and will *not* in themselves ensure quality habilitation and adequate treatment programs." H. R. Conf. Rep. 94-473 at 43; 1975 U. S. Code Cong. & Ad. News at 963. (emphasis supplied).

See also remarks of Senator Cranston, 121 Cong. Rec. 16520 ("the growing realization over the past decade that institutional placement of individuals . . . is inappropriate to their full development to their maximum level of ability"); of Senator Williams, 121 Cong. Rec. 16516 ("Steps to scale down any of these institutions have resulted in not-so-large institutions, often with not much improved care"); of Representative Carter, 121 Cong. Rec. 9976 ("We, as a committee, are well aware that treatment of the developmentally disabled should be conducted in that person's community without unnecessarily institutionalizing him.")

39. E.g., remarks of Senator Cranston, 121 Cong. Rec. 16250; remarks of Representative Carter, 121 Cong. Rec. 9976.

institutions at all.[40] Efforts to assure proper treatment, education and habilitation services in large institutions should not deflect attention from the fact that most of these institutions themselves are anachronisms, and that rapid steps should be taken to phase them out. Many of these institutions by their very nature, their size, their isolation, their impersonality, are unsuitable for treatment, education, and habilitation programs." S. Rep. 94-160 at 32-33.

Given this Congressional purpose, the language of the statute and the findings concerning actual conditions at Pennhurst and in community facilities, the Court of Appeals' judgment is clearly faithful to the Congressional policy and does not raise any issue meriting review by this Court.[41]

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40. The Pennhurst Association petition, p. 16, is, thus, just wrong when it says "Nothing in the Act suggests that institutional settings such as Pennhurst, are inappropriate for all but a few 'probably comparatively rare' mentally retarded individuals." The petitions assertion, p. 16 n. 18, that "for many developmentally disabled persons . . . , a large congregate institution that offers diverse, quality programs will afford more respect for and protection of the person's liberty than would life in a small discrete, community facility" is not properly addressed to the Court, for the Congress has concluded on the matter. As to any individual who may be among the few, the matter is properly presented in the individual determinations, not here.

41. Respondents PARC et al do not gainsay the holding of the court below that "the framers [of § 6010] did not anticipate a shutdown of all institutions when they endorsed a right to habilitation in the least restrictive environment" or that "they recognized that for some [persons] institutions, once improved, might be appropriate." Rather, respondents would submit, on the record and findings below Pennhurst is one institution so anachronistic, so isolated, so impersonal, so impervious to improvement that § 6010 requires that it be rapidly phased out. Therefore, should this Court grant a writ of certiorari on any petition, respondents request a writ be granted on their conditional cross-petition in No. 79-1414 to review the judgment by the court below insofar as it vacates the district court orders prohibiting admissions to Pennhurst and directing its eventual closing.

V. The Remedies Formulated Below Flow Directly From the Statutes and Raise No Issue Meriting Review by the Court

The district court found that implementation of its judgment would be impossible without the appointment of a Master (80a-81a). The Court of Appeals concurred in this finding, writing:

> "In this case, moreover, the court's resort to use of a master is particularly appropriate. After the decision on liability was announced, the [defendants] were afforded an opportunity to devise and present their own remedies for conditions at Pennhurst. They failed to do so." (150a).

Indeed, at two hearings on remedy before the district court state defendants had refused to submit any remedial plan except the one which they had submitted at trial nine months before in defense to liability, a plan which the district court had already rejected in its opinion on liability (28a-29a). Again, the court found state defendants' plan "vague and indefinite" (78a) and found it necessary again to reject it.[42] The county defendants made no suggestions as to what the remedy should be, except for Bucks County defendants who, notwithstanding the position stated in their petition here, p. 17, recommended to the district court the appointment of a master as necessary to implementation. In these circumstances the appointment of a master with the carefully circumscribed duties described by the court below (55a, 58a) was a proper exercise of the court's equity powers.

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42. In addition, the record in this case shows literally dozens of repeated occasions during the last two decades when the state executive had failed to act upon its own plans and undertakings, as well as recommendations and directions of the legislature, of the Governor's Management Review Panel and of their own commissioned studies which would have resulted in the elimination of the statutory violations found by the Court.

The remedies chosen by the district court and approved, as modified, by the Court of Appeals—individual determinations whether any resident needs an improved Pennhurst, the transfer to community facilities of Pennhurst residents for whom these are suitable services,[43] and the establishment of on-going structures, like individual habilitation plans, for the self-policing by defendants of the appropriateness of services[44]—flow directly from the statutes and are finely fitted "to make effective the Congressional purpose." *Resident Advisory Board v. Rizzo*, 546 F. 2d 126, 149 (3d Cir. 1977) *cert. denied* 435 U. S. 908, 98 S. Ct. 1457 (1978).

The subject matter of this case was described, and challenges quite like those here to remedial orders were denied, in *Milliken v. Bradley*, 433 U. S. 267, 287 (1977) where for the Court, the Chief Justice wrote:

> "Children who have been thus educationally and culturally set apart from larger community[45] will inevitably acquire habits of speech, conduct and attitudes which reflect their cultural isolation [,]habits . . . which vary from the environment in which they must ultimately function and compete if they are to enter and be a part of that community. This is not peculiar to race; in this setting, it can effect any children who, as a group, are isolated by force of law

43. Contrary to the Pennhurst Association petition, p. 9, the orders do not require the "construction" of community residential facilities. Of the current 3500 community living arrangements nearly all are houses or apartments which are leased. Certainly the order means expansion of their number as well as the transfer of resources within Pennsylvania's retardation service system from the Pennhurst institutional facility to community facilities, as residents are transferred.

44. The district court had itself eschewed the detailed statement of extensive standards characteristic of cases like *Wyatt, supra* in favor of community-directed relief and monitoring structures.

45. The average age of Pennhurst residents at admission was 14; at the time of trial, on the average, they had been there for 21 years.

from the mainstream.[46] Cf. *Lau v. Nichols*, 414 U. S. 563 (1974)".[47]

On the propriety of the remedies there and here, see *id.* at 291.

VI. The Decision Below Permitting the United States to Intervene as a Party Plaintiff Raises No Issue Meriting Review by the Court

There was a case before the district court when the United States came to it, which in all events had to be determined. Whatever question there may be concerning the standing or authority of the United States to initiate a case like this one is not presented here where the United States was merely granted leave to intervene. *In re Estelle*, 516 F. 2d 480 (5th Cir. 1975) *cert. denied*, 426 U. S. 925 (1976).

The presence of the United States did not alter the scope or dimensions of this case in any way. Among the three sets of plaintiffs, the United States carried its share of the conduct of the litigation, but no more.[48] Among the fourteen expert witnesses presented by plaintiffs, for example, six were presented by the United States, eight by plaintiffs PARC et al. Among plaintiffs' 139 documentary exhibits, 55 were submitted by the United States and 84 by PARC et al. and original plaintiffs. Had the United States not been a party, the burden of proof would have been reallocated among the other parties.

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46. See Act of June 12, 1913 § 1, *supra* at p. 13, creating Pennhurst and S. Rep. No. 94-160 at 27, *supra* at pp. 14-15 and 39.

47. Compare Mr. Justice McReynolds writing for the Court in *Meyer v. Nebraska*, 262 U. S. 390, 401-02 (1923).

48. On the eve of trial, defendants sought a writ of mandamus or prohibition against the participation of the United States in this case; the writ was denied by the Court of Appeals, a stay pending certiorari was denied below and this Court denied an application for stay and the petition for writ of certiorari. *Beal v. Broderick*, 431 U. S. 933 (1977).

CONCLUSION

For the above stated reasons, the Court should deny all of the petitions for a Writ of Certiorari herein.

Respectfully submitted,

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APPENDIX A.

The Legislative Intent of the Pennsylvania Mental Health and Mental Retardation Act of 1966,

Pennsylvania Legislative Journal
76-78 (September 27, 1966)

COMMONWEALTH OF PENNSYLVANIA
LEGISLATIVE JOURNAL—SENATE

THIRD SPECIAL SESSION OF 1966
WEDNESDAY SEPTEMBER 27, 1966

SECOND READING CALENDAR
BILL ON SECOND READING

SB 9 (Pr. No. 13)—Read at length the second time and agreed to,

Ordered, To be transcribed for a third reading.

PETITIONS AND REMONSTRANCES

Mr. PECHAN. Mr. President, I am very happy, as I am sure that the majority of the Members of this Senate are, about the progress of the mental health bill. I would like to make a few remarks, if I may; in fact, I have them prepared.

I think the Mental Health and Mental Retardation Act of 1966, in my opinion, is the noblest piece of legislation to come before the General Assembly at this Session. It will improve what we do now. It atones further for the wrongs we have done, over the centuries, to our fellowmen upon whom the misfortune of mental illness or mental retardation has fallen. We have labeled them "crazy", "insane",

or "feeble-minded". Because their disability was unseen, we have had little sympathy with it. We have judged them responsible for their actions and have punished them. We have locked them up, put bars on their cells, and strait-jackets on their bodies. We have exiled and sometimes forgotten them. We have sometimes cut them off from human society, and abandoned them to their distress and misery.

The object of this legislation is to make it possible for every mentally disabled person to receive the kind of treatment he needs, when and where he needs it. It will make those services available to every citizen in every community which are now available only to a lucky few, in the more progressive communities. It will open more beds in the local general hospitals. It will make available the services of psychiatrists and psychologists, of psychiatric nurses and social workers, of specially trained occupational therapists, of speech and hearing therapists, of activities directors and of child care workers. It will supplement the benefits of therapy with daytime and evening programs of activity which will call back to reality the erring mind, which will re-create and strengthen the ties which bind one human being to another and make us comfortable in each others' company. It will provide productive activity for those who can work only in a sheltered situation, and for those who are able, it will prepare them to go back to the customary world of business and industry, or to go forth into it for the first time, as the case may be. For those in acute distress, service will be available twenty-four hours a day, and the violent will find protective care instead of the harsh custody of jail.

There will still be those who will need a long stay in an institution, some even for whom this is the necessary and the only kind provision for the rest of their lives. We are not about to close our State schools and hospitals or

our State mental hospitals. The great point is that we shall know that the treatment program of one of these institutions is the indicated treatment before the patient leaves his community. Diagnosis and evaluation of his condition will precede the disposition of his case, and everything possible will be done for him in his own hometown.

If he responds to the program of the institution and the time comes when he is ready to return home, he will not be turned out into the cold. These same community services will be there to help ease the transition back into a normal life. Nobody will be lost from sight. Care will be continuous, even though the patient may move from in-patient to out-patient care, from hospital to workshop, from halfway house to foster home.

Not only will it be easy for a mentally disabled person to find the treatment he needs, but it will also be easy for him, under certain circumstances, to leave treatment when he has derived the full benefit from it, since the bill provides for voluntary admissions. Even in commitment, there is a large measure of flexibility, since there can be commitment to out-patient as well as to in-patient care.

A benefit of the legislation in which we will all share is that in every part of the State there will be a point at which we can receive information, to which cases can be referred before they become acute, where we professional men and the community agencies can get advice and consultation on the perplexing problems which often come to our attention first.

To give them their designations in the proposed Act, these community services, which must be made available in every community, are:

Short term in-patient services other than State-operated facilities.

Out-patient services.

Partial hospitalization services.

Emergency services, twenty-four hours per day, which shall be provided by, or available within at least one of the types of services specified heretofore in this paragraph.

Consultation and education services to professional personnel and community agencies.

Aftercare services for persons released from State and community facilities.

Specialized rehabilitative and training services including sheltered workshops.

Interim care of mentally retarded persons, who have been removed from their homes and who having been accepted, are awaiting admission to a State-operated facility.

Unified information and referral services.

The manner in which services will be made available will be determined by County Government. There need be no disruption of existing services. The local general hospital will provide in-patient care for the mentally ill, as it does for those with other kinds of illnesses. The out-patient clinic, where there is one, will continue to give out-patient service. The workshop or the day care center for the mentally retarded will go on functioning as it does now. However, these services, and new ones to be created where they are lacking, will be drawn together and co-ordinated by a small county staff, so that continuity of care for the patient may be assured.

This is a function which is essential, and which County Government can best perform. Thus, local government is tied into a partnership which already includes the State and the Federal Government. The Federal Government has only recently concerned itself with the problems of mental health and mental retardation, but Federal legislation and Federal funds for the construction of facilities and the staffing of services have given a mighty impetus to the improvement of services for the mentally disabled.

This partnership will extend into policy-making, as well as into the administration and financing of the program. Representatives of the County Commissioners and of both the Legislative and Executive Branches of the State Government will co-operate in formulating policies.

The financial burden of caring for the mentally ill and retarded rests largely on the State now, and will continue to do so under the new Act. The State will bear the entire cost of hospitalization of the mentally ill, whether it is in the local general hospital or the State mental hospital, whether it is twenty-four hours around the clock, or for the day or the night only. The State will also bear the cost of institutional care of the mentally retarded, whether actually residing in a State school and hospital, or being cared for in a private institution or foster home, while awaiting admission. It will also bear the major share of the cost of other services and, as we have amended the bill, it will take care of ninety per cent of the cost.

That may sound like a lot of money, but it is small compared to the human lives that it will restore to productive citizenship. We must also bear in mind that many sources of income will be tapped to support these services. Most people will be able to pay their own way, either because they have the money or because they are covered by health insurance. We will take full advantage of the medical assistance (Pennsycare) program of which the Federal Government pays over half. In the beginning, the cost to the State should be somewhere around $12,000,000 to $15,000,000, a year, while many counties will have to put in very little more than they are now contributing to the support of services for the mentally ill and retarded. Even ten years from now, the increased cost in many counties will be absorbed in the increased value of taxable property.

Sure, it will cost money. However, in the total State budget, this is not a significant sum. Every time a person is preserved from a life of dependency, every time a man goes back to his job, the financial burden on the State and on the counties is lifted.

Let me close by reminding you who want this legislation. I am sure the Governor wants it—he called a special session to consider it. The County Commissioners want it—they approved it in principle at their annual meeting and, through a committee, have labored with us to produce a sound and workable law. The citizens' organizations, which are especially concerned about the mentally disabled, want it. They participated by the thousands in the two years of planning which led up to the preparation of the bill, and have followed its course closely. Nobody got everything he wanted in the bill which is before you, but all were willing to submerge their own interest in the common good for the good of the mentally ill and the mentally retarded of this Commonwealth. I call on you to remember those who want this legislation most; namely, the ill and distressed, who will benefit directly from it, and to remember the humane and progressive tradition of this Commonwealth, and to vote for this enlightened measure.

Mr. SESLER. Mr. President, I can only concur in the remarks made by my distinguished colleague from Armstrong County. I would ask that he add one more remark. During the next Session of the Legislature, I want him to use his enormous influence in the dental profession, in view of the largess that we demonstrated yesterday, to bring it upon himself to ask the members of his profession to see whether they can provide free dental care and teeth for all of the mentally ill who need them. I am sure that we will see that the gentleman will work on this program during next year.

However, Mr. President, at least, in so far as the Senate is concerned, I would like to say that we have

reached a conclusion, finally, on the Mental Health and Mental Retardation Act of 1966. It is our hope that the House will act speedily on this matter and that the bill will be a reality and pass into law within the very near future. At this present time, I see no obstacles to that accomplishment.

In hearing Senator Pechan speak, I am reminded, of course, of the efforts exerted by Governor George Leader who did so much toward the cause of mental health in Pennsylvania, and for President Kennedy who promoted so assiduously the idea of the community mental health services.

We hope that this bill will, indeed, be a milestone in the field of mental health and mental retardation. We have made concessions, on our side of the aisle, I think, in order to effect the passage of this bill. I would like to remind our friends in County Government that we have given a great deal of responsibility to the County Commissioners. They are charged with the help of professional staffs in our Department of Public Welfare with the duty of carrying out these programs. We have made concessions in that we are going to permit them to have control over their Administrators and regional programs. They will have the ability to discharge them, if they do not think that they are carrying out the program. We were not happy with this, but we conceded that if it was necessary for the passage of the bill, we were willing to make such a concession. We want to make it clear, for the record, that we are giving this responsibility to our County Governments, and we are giving them a great deal of money. One of the amendments just adopted today has provided that the State will have to reimburse the counties for ninety per cent of the cost of the program. We are giving them a certain degree of freedom. However, we must remind them that the counties had a program of control for taking care of the mentally ill, prior to 1937,

when they failed to do an adequate job. It may be that they lacked the finances at that time, and that they lacked the public's support. However, today, I think that the public's support is there. I trust that the Commonwealth will be there with the adequate finances.

We are now going to look for the County Commissioners to expend every effort they have, in working in co-operation with the Department of Public Welfare and with the Advisory Citizens Board, throughout the various counties of the Commonwealth, to see that they take immediate steps to begin to formulate these plans. We should see to it that they set aside politics and bend every effort to the end that we will have the maximum utilization of all of our resources, both public and private, for the benefit of those less fortunate than ourselves.

When you realize that practically one out of ten of every Pennsylvanian has some problem in mental health, you will realize how vast the scope of this problem is. However, I think, we now have sketched in broad, general terms the framework of a program which can provide a continuum of services—out-patient, in-patient, diagnostic treatment, evaluation and research, a procedure of commitment under almost all conceivable types of circumstances.

I hope that we can focus attention on the local level, because if there was ever an example of a co-operative effort, which involves so many citizens and private groups as this legislation, I do no know what it is. We are going to give it control down on the local level; we are giving it a flexible degree of control. So, I am saying today—at least, I, speaking for myself—that we are charging County Governments with this tremendous responsibility. We hope that they will take these words to heart, in the spirit in which we worked, in a bipartisan effort. We Democrats, on this side of the aisle, have certainly, throughout the entire course of this legislation, demonstrated our in-

terest in producing a program that is going to be both realistic and, yet, broad and imaginative in its scope.

With this in mind, Mr. President, we are happy that we have finally reached an agreement which we hope will be a happy, working agreement, realizing that we had to exercise the arduous impossible.

Mr. BELL. Mr. President, in view of this wonderful feeling of all the Members of the Senate towards our mentally ill, I trust that the next Session of the Legislature will see the great need in our institutions for more appropriations; that we give to our mental health program the sinews to put this program into effect.

I trust that, during the next Session, the Department of Public Welfare will put in proper requests, so that we can have the General State Authority build adequate facilities to take care not only of those mentally ill, but to provide, immediately, proper facilities for our mentally retarded children.

Mr. STROUP. Mr. President, I must say that I am very much pleased that the gentlemen who have spoken on the floor, here this afternoon, have all been overwhelmingly for the enactment of this bill, tomorrow, into law. I shall save my laudatory remarks until that time.

ADJOURNMENT

Mr. STROUP. Mr. President, I move that the Third Special Session do now adjourn until Wednesday, September 28, 1966, immediately following adjournment of the Special Session.

Mr. LANE. Mr. President, I second the motion.

The motion was agreed to.

Supreme Court, U. S.
FILED
MAY 27 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408, 79-1414, 79-1415, and 79-1489

In the Supreme Court of the United States

OCTOBER TERM, 1979

PENNHURST STATE SCHOOL AND HOSPITAL, ET AL., PETITIONERS
v.
TERRI LEE HALDERMAN, ET AL.

MAYOR OF CITY OF PHILADELPHIA, ET AL., PETITIONERS
v.
TERRI LEE HALDERMAN, ET AL.

PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, ET AL., PETITIONERS
v.
PENNHURST STATE SCHOOL AND HOSPITAL, ET AL.

COMMISSIONERS AND MENTAL HEALTH/MENTAL RETARDATION ADMINISTRATORS FOR BUCKS COUNTY, ET AL., PETITIONERS
v.
TERRI LEE HALDERMAN, ET AL.

PENNHURST PARENTS-STAFF ASSOCIATION, PETITIONER
v.
TERRI LEE HALDERMAN, ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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In the Supreme Court of the United States

OCTOBER TERM, 1979

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No. 79-1408

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v.

TERRI LEE HALDERMAN, ET AL.

No. 79-1414

PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, ET AL., PETITIONERS

v.

PENNHURST STATE SCHOOL AND HOSPITAL, ET AL.

No. 79-1415

COMMISSIONERS AND MENTAL HEALTH/MENTAL RETARDATION ADMINISTRATORS FOR BUCKS COUNTY, ET AL., PETITIONERS

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TERRI LEE HALDERMAN, ET AL.

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v.

TERRI LEE HALDERMAN, ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 92a-196a)[1] is reported at 612 F. 2d 84; the opinion

[1] "Pet. App." refers to the separately bound Joint Appendix in No. 79-1404.

of the district court (Pet. App. 6a-75a) is reported at 446 F. Supp. 1295.

JURISDICTION

The judgment of the court of appeals was entered on December 13, 1979. The petitions in Nos. 79-1404, 79-1414, 79-1408 and 79-1415 were filed on March 12, 1980, and the petition in No. 79-1489 was filed on March 20, 1980. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

QUESTIONS PRESENTED

1. Whether Pennsylvania law provides mentally retarded persons in Pennsylvania a right to care and habilitation appropriate to their individual needs, and whether the right is judicially enforceable against local, as well as state, officials.

2. Whether the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. 6001 *et seq.*, provides mentally retarded persons in the custody of a state receiving federal funds under the Act a judicially enforceable right to receive care and habilitation appropriate to their needs in the setting that least restricts their personal liberty.

3. Whether the district court abused its discretion under Rule 24(b), Fed. R. Civ. P., by allowing the United States to intervene.

4. Whether the plaintiff class should have been decertified.

5. Whether the remedy violates the principles of federalism and exceeds the authority of federal courts.

STATEMENT

A. Procedural History

This case began with the filing of a class action in the United States District Court for the Eastern District of Pennsylvania by residents of the Pennhurst State School and Hospital, an institution in Pennsylvania for residential care and habilitation of mentally retarded persons.[2] The certified plaintiff class is all persons "who * * * have been or may become residents of Pennhurst" (Pet. App. 14a). The Pennsylvania Association for Retarded Citizens, several additional individual mentally retarded plaintiffs, and the United States were permitted to intervene as plaintiffs.[3] Defendants are various state and local officials having the responsibility for the operation of Pennhurst and for placing mentally retarded persons there as residents. After a lengthy trial, the district court found that conditions at Pennhurst were so inadequate and debilitating that they abridged plain-

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[2] The district court explained that: " '[h]abilitation' is the term of art used to refer to that education, training and care required by retarded individuals to reach their maximum development" (Pet. App. 10a).

[3] Following trial, and after notice of appeal had been filed, petitioners in No. 79-1489 sought to intervene in the district court and intervention was denied. The denial was affirmed by the court of appeals (79-1489 Pet. App. 213a-217a), but that court subsequently allowed intervention for the purpose of seeking certiorari (79-1489 Pet. 6 n.9).

tiffs' rights under the Due Process Clause, the Equal Protection Clause, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and Pennsylvania law (Pa. Stat. Ann. tit. 50, § 4201 *et seq.* (Purdon 1969)). The district court ordered that certain interim steps be taken to improve conditions at Pennhurst.[4] It also ordered defendants to make plans to close Pennhurst, and to remove its residents to more appropriate and less restrictive community living arrangements, in accordance with the deinstitutionalization policy that has been adopted in Pennsylvania.

On appeal, the en banc court of appeals held that by subjecting plaintiffs to the conditions at Pennhurst, defendants were violating both Pennsylvania statutes (Pa. Stat. Ann. tit. 50, § 4201 *et seq.* (Purdon 1969)) and the Developmentally Disabled Assistance and Bill of Rights Act (42 U.S.C. 6002-6081).[5] However, the court of appeals reversed the district court's order requiring the eventual closing of Pennhurst, and instead directed the district court, or the special master appointed by the court, to supervise the defendants' determinations, on a case-by-case basis, of the proper placement of Pennhurst residents (Pet. App. 150a-151a). The court said (Pet. App. 158a-160a):

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[4] The district court first attempted, without success, to obtain from the defendants proposals for appropriate relief to correct the harmful conditions found to exist (Pet. App. 77a-79a).

[5] The court of appeals accordingly did not decide whether petitioners' conduct violated the Constitution or Section 504 of the Rehabilitation Act of 1973 (Pet. App. 131a & n.28, 141a).

> Of course, deinstitutionalization is the favored approach to habilitation * * *. Thus, on remand, the court or the Master should engage a presumption in favor of placing individuals in [community living arrangements]. But the special needs and desires of individual patients must not be neglected in the process.
>
> * * * * *
>
> [S]tate and federal laws plainly require that if Pennhurst is to remain open for at least some patients, it must be dramatically improved so as to provide adequate habilitation. Neither should our willingness to permit retention of Pennhurst as an institution available for those who cannot be treated in any less restrictive environment be construed as an invitation to the appellants to desist from opening up alternative community facilities.

Three judges dissented (Pet. App. 162a). They would have found that conditions at Pennhurst violated plaintiffs' constitutional and statutory rights, but would have limited relief to correcting these conditions.

B. The Findings

The Pennhurst State School and Hospital, which is owned and operated by the State of Pennsylvania, has been overcrowded and understaffed since its founding in 1908. At the time of trial, the resident population was 1230 mentally retarded persons, although in the early 1960's there were 4000 residents (Pet. App. 19a). Residents sleep in large overcrowded wards and spend their days in large day

rooms; their schedules are determined by the needs of the institution (Pet. App. 21a).

All parties agreed at trial that Pennhurst "as an institution is inappropriate and inadequate for the habilitation of the retarded" (Pet. App. 23a).[6] The district court found the "average resident receives only 1½ hours of programming per weekday and no programming on weekends" (*id.* at 24a); because of staff shortages, residents are not placed in special programs to which they are referred (*id.* at 25a). For example, as of April 1977, 511 residents were on the waiting list for occupational therapy; 106 residents were on the waiting list for speech therapy; only 143 of the three to four hundred residents who needed physical therapy to prevent physical deterioration were receiving it. Moreover, 75 to 100 residents lacked specially adapted wheelchairs that they needed; only 51 of 300 residents who needed hearing aids had been provided them (*id.* at 25a-26a).

Proper habilitation cannot be provided to retarded persons unless those responsible for providing such programs are aware of individual needs. Yet, the district court found that the relevant patient evaluations at Pennhurst did not meet professional standards (Pet. App. 27a).

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[6] Pennsylvania's purpose in maintaining mentally retarded persons in institutions is "[t]o assure * * * the availability and equitable provision of adequate * * * mental retardation services for all persons who need them * * *." Pa. Stat. Ann. tit. 50, § 4201(1) (Purdon 1969).

Although a committee at Pennhurst recommended against isolating residents except in medical emergencies and specifically recommended against the use of isolation as punishment, isolation was still used, simply because there was insufficient staff to provide the attention to residents that would make isolation unnecessary. Physical restraints were used for the same reason and have been physically harmful, including causing one death by strangulation (Pet. App. 31a-32a).

Psychotraupic drugs were used to control residents rather than to treat them, and their use was inadequately monitored. The administration of such drugs has had debilitating or hazardous side effects and has impeded, rather than enhanced, habilitation of residents (Pet. App. 33a).

The physical environment at Pennhurst was hazardous and unsanitary. Pinworm and infectious diseases were common. The environment not only was not conducive to learning new skills, it contributed to losing skills already learned. Injury of residents by other residents and through self-abuse was common: in January 1977, there were 833 minor and 25 major injuries reported (Pet. App. 34a-35a).

Pennsylvania accepts the "normalization" theory that a retarded person will develop and learn more if placed in an environment that is as close to a normal one as is possible. Toward that end, the state has established "community living arrangements" in the five-county area from which the Pennhurst population is drawn. However, there are insufficient

living units, vocational opportunities, and day care facilities in the area to provide placement for all Pennhurst residents; from 1972 until trial, only 186 Pennhurst residents were transferred into community living arrangements (Pet. App. 43a).[7]

These findings were not disputed on appeal; they were affirmed by the court of appeals (Pet. App. 105a-106a).

ARGUMENT

1. The court of appeals held that Pennsylvania law requires petitioners to furnish mentally retarded persons adequate treatment and habilitation (Pet. App. 125a-127a). Although Pennsylvania's Mental Health and Mental Retardation Act of 1966, Pa. Stat. Ann. tit. 50, § 4201 *et seq.* (Purdon 1969), is unconstrued by the highest state court, decisions of lower state and federal courts fully support the construction given it by the court of appeals. *E.g.*, *In re Joyce Z*, 4 Pa. D. & C. 3d 596 (C. P., Allegheny Co. 1975); *County of Allegheny* v. *Commw., Dept. of Pub. Welfare*, 381 A.2d 1014, 1016 (Pa. Commw. Ct. 1978); *Eubanks* v. *Clarke*, 434 F. Supp. 1022, 1027 (E.D. Pa. 1977). Thus, state law requires the state and county petitioners to furnish "a comprehensive program for

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[7] Nevertheless, the state petitioners "agreed that the retarded should be removed from Pennhurst and readily admitted that the only reason that the litigation was necessary was because they wished to accomplish the closing of Pennhurst as a residence for the retarded, pursuant to their own schedule which was vague and indefinite" (Pet. App. 78a, 42a).

the care, treatment and rehabilitation of mentally disabled and mentally retarded persons." *Hoolick* v. *Retreat State Hospital*, 354 A.2d 609, 611 (Pa. Commw. Ct. 1976), aff'd, 382 A.2d 739 (Sup. Ct. 1978). It is the duty of the state petitioners under Pa. Stat. Ann. tit. 50, § 4201(1) (Purdon 1969):

> To assure within the State the availability and equitable provision of adequate mental retardation services for all persons who need them * * *.

As the findings made clear, the confinement of mentally retarded persons in Pennhurst is neither "adequate" nor "equitable": the district court found, and the court of appeals affirmed, that many of Pennhurst's residents not only receive inadequate services, but are confined in an environment that produces regression in skills and physical and mental harm.

The petitioning city and county officials claim that state law places no responsibility on them for the wrong done to Pennhurst residents (79-1408 Pet. 9-10; 79-1415 Pet. 15). But, as the court of appeals observed (Pet. App. 130a):

> the Counties have joined inextricably in the states' provision—or lack of provision—of treatment * * * the Counties arrange for admission to Pennhurst through their operation of Base Service Units. Often, the district court found, the County Base Service Units fail to investigate alternatives to institutional placements, thereby consigning the mentally retarded to inadequate living conditions. * * * Having thus participated for so long in the institutional practices at Penn-

> hurst, the Counties cannot at this late date escape—by pointing the finger of responsibility elsewhere—the statutory duty to provide adequate habilitation.

The relief ordered by the court of appeals (Pet. App. 155a-160a) is entirely consistent with the statutory responsibilities of petitioners. That relief is premised on three principles: First, the deinstitutionalization process established by the Pennsylvania legislature (see Pet. App. 43a-44a) should continue. Second, because "[t]he state statute, like the federal statute, was focused on *individual* needs" (Pet. App. 157a), the court of appeals reversed the district court's requirement that Pennhurst be eliminated as an institution caring for mentally retarded persons; individuals who will benefit from institutionalization and would be harmed by a less restrictive alternative facility may still be placed in and treated at Pennhurst (*id.* at 158a-159a).[8] Third, in whatever facility individuals are placed, the state and local petitioners must provide them with adequate habilitative services as required by state law; this means that the harmful conditions found to exist at Pennhurst must be eliminated (*id.* at 160a-161a).

Without furnishing any Pennsylvania authority suggesting that the courts' treatment of respondents' state law claim is "in conflict with applicable state

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[8] This modification of the relief ordered by the district court satisfies the intervening petitioner's concern (79-1489 Pet. 9, 16 n.18, 18) that severely mentally retarded persons should not be thrust into settings to which they cannot adjust.

* * * law" (Rule 19(1)(b) of the Rules of this Court), petitioners ask this Court to reverse purely Pennsylvania law decisions of two federal courts sitting in Pennsylvania. Cf. *Huddleston* v. *Dwyer*, 322 U.S. 232, 237 (1944); *Estate of Spiegel* v. *Commissioner*, 335 U.S. 701, 707-708 (1949). Nor can this Court overlook the state law issue if it chooses to review this case since, as the analysis above shows, the relief that the courts below granted is based on their acceptance of the state, as well as the federal claim.[9]

2. In any event, the court of appeals' application of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. 6001 *et seq.*, the first appellate decision to apply this statute, was correct. The Act is the culmination of congressional actions taken over a number of years for the purpose of improving the care and training of developmentally disabled

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[9] Petitioners argue that the court of appeals' requirement that the district court "engage in a presumption that individuals should be placed in [community living arrangements]" (Pet. App. 159a) is derived solely from the Developmentally Disabled Assistance and Bill of Rights Act. But the court of appeals explained (Pet. App. 157a) that the intent of the Pennsylvania law is "to make it possible for every mentally disabled person to receive the kind of treatment he needs, when and where he needs it." Both state and federal law, the court held, make it "fitting that the Commonwealth be required to undertake a case-by-case investigation into how each person's rights may best be facilitated" (*ibid.*). In this context, the direction to "engage in a presumption" simply requires a method of proceeding with individual determinations that is consistent with Pennsylvania's acceptance of the policy of normalization (see *supra*, pages 8-9).

persons.[10] See H.R. Rep. No. 95-1188, 95th Cong., 2d Sess. 3-7 (1978). The 1975 amendments, in addition to providing federal funds for centralized planning and coordination of the various services provided by a state to developmentally disabled persons, create rights enforceable in federal courts: 42 U.S.C. 6010 (1) and (2) announce the right of the developmentally disabled "to appropriate treatment, services, and habilitation for such disabilities" and to have "treatment, services, and habilitation * * * designed to maximize the developmental potential of the person * * * in the setting that is least restrictive of the person's personal liberty."

The legislative history cited by the court of appeals (Pet. App. 132a-135a) establishes that the Act expresses a preference for deinstitutionalization of mentally retarded persons. Institutionalization is allowed only if it provides "treatment, services and habilitation which is appropriate to the needs of such persons" and meets the minimum standards specified in 42 U.S.C. 6010(3). Thus, the court of appeals followed the congressional purpose and intent by requiring that only those persons who need institutionalization should be placed at Pennhurst and that the offending conditions there should be eliminated.[11]

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[10] Mental retardation is a developmental disability within the contemplation of the Act (42 U.S.C. 6001(7)).

[11] The petition of the county officials suggests that the decision of the court of appeals "establishes a right in 6.75 million retarded citizens [throughout the United States] to receive habilitative services in the least restrictive setting." 79-1415

The rights secured to mentally retarded persons by Section 6010 are judicially enforceable through civil actions such as this. This Section was the product of a conference of the two Houses of Congress, and in the conference report (H.R. Conf. Rep. No. 94-473, 94th Cong., 1st Sess. 42 (1975)) the section was described as being included "in recognition by the conferees that the developmentally disabled, particularly those who have the misfortune to require institutionalization, have a right to receive appropriate treatment for the conditions for which they are institutionalized, and that this right should be protected and assured by the Congress and the courts."

In 1978, 42 U.S.C. 6010 was amended by Pub. L. No. 95-602, Section 507, 92 Stat. 3007, to add:

> The rights of persons with developmental disabilities described in findings made in this section are in addition to any constitutional or other rights otherwise afforded to all persons.

Pet. 8 n.5. But the opinion below adjudicates only the rights of the class, consisting of "current residents of [Pennhurt, and] all mentally retarded residents of the five counties of southeastern Pennsylvania who might in the future be placed in Pennhurst" (Pet. App. 96a). The court accordingly focused on the rights of those institutionalized at Pennhurst, and concluded that when the state accepts the responsibility for the care of the mentally disabled and accepts federal funding under the Act to assist in performing that responsibility, it must provide that care in a manner consistent with the Act. The court did not consider, much less adjudicate, the quite different question whether the state must provide for the care of all its mentaliy disabled citizens.

This addition dispels any argument that the rights described in Section 6010 are simply declarative of rights granted elsewhere in the Constitution or statutes. It also fully answers petitioners' arguments that the Act is no more than a funding statute. Congress also intended in the Act to create a private cause of action for the benefit of the developmentally disabled.[12] The court of appeals was accordingly correct in concluding (Pet. App. 115a-117a) that this statute satisfies this Court's criteria for the implication of a private cause of action. See *Cort* v. *Ash*, 422 U.S. 66, 78 (1975); cf. *Cannon* v. *University of Chicago*, 441 U.S. 677 (1979); *Touche Ross & Co.* v. *Redington*, 442 U.S. 560 (1979); *Transamerica Mortgage Advisors, Inc.* v. *Lewis*, No. 77-1645 (Nov. 13, 1979).

3. The district court allowed the United States to intervene in this action under Rule 24, Fed. R. Civ. P., presumably under part (b), governing permissive intervention. The court of appeals concluded that "[c]learly, * * * the district court did not abuse its discretion in permitting [that] intervention" (Pet. App. 103a). There is no need for further review of that question by this Court; this Court's resolution of that question would affect neither the findings of statutory violation nor the relief ordered by the court below.

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[12] This dual intent is emphasized in the short title of the Act. Had Congress intended to enact *only* a funding statute, it would scarcely have called it the "Developmentally Disabled Assistance and Bill of Rights Act." Pub. L. No. 94-103, Section 1, 89 Stat. 486.

There was, in any event, no "clear abuse" of the district court's discretion warranting the reversal of its decision to permit intervention. See *Allen Calculators, Inc.* v. *National Cash Register Co.*, 322 U.S. 137, 142 (1944). The United States provides a large portion of the funds for the operation of Pennhurst through the Social Security Act, Title XIX, 42 U.S.C. 1396d *et seq.*, even though Pennhurst has never fully met standards set by federal regulations for receipt of those funds (Pet. App. 19a n.14). While at the time of intervention the suit was cast in constitutional terms, it was unmistakably directed toward the conditions at Pennhurst (Pet. App. 47a). As such, it raised issues affecting the interests of the United States reflected in Social Security Act funding and the related regulations. Following the United States' intervention, the suit quickly became one where the principal claims rest upon federal statutes that impose substantial responsibilities on the Department of Health and Human Services. See, *e.g.*, 42 U.S.C. 6062, 6063, 6065. Rule 24(b) provides:

> When a party to an action relies for ground of claim or defense upon any statute or executive order administered by a federal or state governmental officer or agency * * * the officer or agency upon timely application may be permitted to intervene in the action.

Thus, the rule expressly permits government intervention when a claim arises such as the one decided by the court of appeals.[13]

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[13] Rule 24(b) is designed to allow trial courts to consider governmental intervention "with a fresh and more hospitable

Despite petitioners' claims (79-1404 Pet. 18-19) there is no conflict between the decision below and *United States* v. *Solomon*, 563 F.2d 1121 (4th Cir. 1977), and *United States* v. *Mattson*, 600 F.2d 1295 (9th Cir. 1979). The United States initiated those cases based on an implied right of action to enforce constitutional rights of institutionalized persons. Cf. *United States* v. *City of Philadelphia*, 482 F. Supp. 1248 and 1274 (E.D. Pa. 1979), appeal pending, No. 80-1348 (3d Cir.); *United States* v. *Elrod*, No. 76-C-4768 (N.D. Ill. May 16, 1978), appeal pending, No. 79-1394 (7th Cir.). The holding that there is no such implied right to initiate suit does not apply to intervention explicitly allowed by Rule 24(b).[14] Moreover, *Solomon*, *supra*, 563 F.2d at 1125, 1129 (concurring opinion) and *Mattson*, *supra*, 600 F.2d at 1299 n.6, both recognize the authority of the United States to sue to enforce conditions of federal grants.[15]

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approach," *Nuesse* v. *Camp*, 385 F. 2d 694, 705 (D.C. Cir. 1967), even though a government "claim or defense" in the usual sense may not be present. See *SEC* v. *United States Realty & Improvement Co.*, 310 U.S. 434, 459 (1940); 3B *Moore's Federal Practice* ¶ 24.10[2] (2d ed. 1980).

[14] In any event, Congress has enacted H.R. 10 (126 Cong. Rec. S4628 (daily ed. May 6, 1980), 126 Cong. Rec. H3500 (daily ed. May 12, 1980)) which, if signed by the President, will effectively overrule *Solomon* and *Mattson* by giving the Attorney General explicit authority to sue to protect the constitutional rights of institutionalized persons.

[15] Under the Developmentally Disabled Assistance and Bill of Rights Act, "[t]he Federal Government * * * [has] an obligation to assure that public funds are not provided to any institutional * * * program" that does not comply with the Act. 42 U.S.C. 6010(3).

4. Petitioner in No. 79-1489 urges this Court to grant certiorari to consider whether the courts below properly refused to divide the class into subclasses, *i.e.*, those who "believed that the closing of Pennhurst would cause considerable harm" (79-1489 Pet. 18) and those who seek the removal of all residents from Pennhurst. However, whether or not there should have been such a division is now irrelevant. The court of appeals ruled that the district court had incorrectly required the closing of Pennhurst, the only issue on which the opinion of the class is alleged to have been divided; the court of appeals did require improvement of living conditions there for those who remain, or who may be placed there in the future, "an objective with which no resident of Pennhurst could disagree" (*ibid.*). To implement the court of appeals' order, what remains is the proper assignment of individual class members either to community placement or to Pennhurst. This, however, requires a determination of the "special needs and desires of individual patients" (Pet. App. 159a)—not a class question at all.

5. Petitioners in Nos. 79-1404, 79-1408 and 79-1415 challenge the propriety of the relief granted as inconsistent with principles of federalism.[16] None of

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[16] In No. 79-1404, it is urged that the use of a master violates Rule 53, Fed. R. Civ. P. However, it is common and entirely proper for courts to employ masters to assist them in devising the specific and necessary measures to effect a complex remedy. *E.g.*, *Gary W.* v. *Louisiana*, 601 F.2d 240, 244-246 (5th Cir. 1979); *Morgan* v. *Kerrigan*, 530 F.2d 401, 427 (1st Cir.), cert. denied, 426 U.S. 935 (1976); *Cruz* v. *Hauck*, 515 F.2d

these contentions merit review here. If, as the court of appeals held, petitioners have violated rights secured to plaintiffs by state and federal law, it is the duty of federal courts "to adjust their remedies so as to grant the necessary relief." *Bell* v. *Hood*, 327 U.S. 678, 684 (1946). While considerations of federalism may militate against permitting certain civil actions to lie, *e.g.*, *Rizzo* v. *Goode*, 423 U.S. 362 (1976), it has never been thought that those principles preclude an equitable remedy necessary to bring about the realization of rights found to exist and to have been violated. *Milliken* v. *Bradley*, 433 U.S. 267, 281-282, 291 (1977).[17]

322, 328-331 (5th Cir. 1975), cert. denied, 424 U.S. 917 (1976); *Davis* v. *Watkins*, 384 F. Supp. 1196 (N.D. Ohio 1974); *Pennsylvania Ass'n for Retarded Children* v. *Pennsylvania*, 334 F. Supp. 1257 (E.D. Pa. 1971); *Hart* v. *Community School Bd. of Brooklyn, N.Y., School Dist. #21*, 383 F. Supp. 699, 766-767 (E.D. N.Y. 1974).

[17] Moreover, the district court's order, as affirmed by the court of appeals, directs the petitioners themselves to develop the individualized program plans for the members of the class, and to make and monitor suitable living arrangements for each class member (Pet. App. 79a-80a, 151a). The master's responsibility is to assure that these plans and arrangements are consistent with the court's orders and are implemented (Pet. App. 81a-82a). Thus, contrary to petitioners' claims (79-1404 Pet. 16-17; 79-1408 Pet. 11-12; 79-1415 Pet. 16-17; 79-1489 Pet. 7-9), the court's order does not deprive petitioners of their responsibility for supervising the care and treatment of the mentally disabled; it simply assures that the responsibility will be exercised in accordance with the governing statutes.

CONCLUSION

The petitions for a writ of certiorari should be denied.

Respectfully submitted.

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Nos. 79-1404, 79-1408, 79-1415, and 79-1489

In the Supreme Court of the United States

OCTOBER TERM, 1979

PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
Petitioners,

v.

TERRI LEE HALDERMAN, *et al.*,
Respondents.

On Petitions for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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PETITIONERS' REPLY MEMORANDUM

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PETITIONERS' REPLY MEMORANDUM

In their briefs in opposition, Respondents raise two new arguments that warrant reply.[1]

I. The briefs in opposition for Halderman, *et al.*, (the "Halderman Respondents") and for the Pennsylvania Association for Retarded Citizens, *et al.*, (the "PARC Respondents") misconstrue both the reach of the state law decision made by the court below and the "authority" supporting it. In their eagerness to avoid

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[1] Petitioners in Nos. 79-1404, 79-1408, 79-1415, and 79-1489 jointly file this Reply Memorandum.

review by this Court of an admittedly significant [2] decision interpreting an important federal statute, Respondents urge that the Pennsylvania Mental Health/Mental Retardation Act of 1966, 50 P.S. §§ 4101 *et seq.*, independently supports the decision of the Court of Appeals. Neither Pennsylvania law, nor more significantly the decision below, supports Respondents' contrived claim. On the contrary, the Court of Appeals made the reach of its state law decision unmistakably clear: "All that section 201 [of the Mental Health/Mental Retardation Act] promises, and all that we hold, is that *to the extent Pennsylvania maintains facilities for the mentally handicapped, those facilities must provide adequate treatment or habilitation.*" Jt. App. 127a (emphasis supplied). Hence, the assertion that the Court of Appeals relied on state law to support the massive relief ordered below, including the creation of *new* facilities, is plainly incorrect.

A. The Court of Appeals premised its affirmance, with minor modifications, of the District Court's Order of March 17, 1978 on two distinct legal conclusions: first, that the mentally retarded have a right to treatment or habilitation; and, second, that such treatment or habilitation must be provided in the least restrictive environment. Both holdings are essential to support the Order of the District Court. As modified, that Order requires the provision of Community Living Arrangements for all retarded class members, except in those "comparatively rare," Jt. App. 139a, cases in which "an improved Pennhurst is the *only* appropriate place." Jt. App. 160a (emphasis added).

The Court of Appeals specifically recognized that it was engaged in a two-step analysis, discussing "The Right to Treatment or Habilitation," Jt. App. 109a-130a,

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[2] Halderman Br. at 27; PARC Br. at 18.

and "The Right to the Least Restrictive Environment," Jt. App. 130a-141a, in wholly separate sections. The section dealing with the right to treatment is broken down into two subsections, "A. Federal Statutory Law," Jt. App. 109a, and "B. State Law," Jt. App. 122a. The section dealing with the right to the least restrictive environment is also broken down into two subsections, "A. The Developmentally Disabled Assistance and Bill of Rights Act," Jt. App. 131a, and "B. Section 504 of the Rehabilitation Act of 1973." Jt. App. 140a. This latter section, finding a judicially enforceable right to the least restrictive environment, was essential to the disposition and relief ordered below.

In its discussion of the least restrictive environment, the court below relied exclusively upon the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§ 6001 *et seq.* (the "DD Act").[3] Although in subsection B, Jt. App. 140a-141a, the court discussed § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the court found it unnecessary to consider its application to the right to the least restrictive environment, since it had already found such a right in the DD Act. "One clear federal statute announces the governing rule, and one is enough." Jt. App. 141a (emphasis added). Thus the Court of Appeals' ruling, finding a right to the least restrictive environment, does not rest on state law, notwithstanding Respondents' determinedly repetitive claims to the contrary.

B. Community Living Arrangements are nowhere mentioned in the governing Pennsylvania statute, the Mental Health/Mental Retardation Act of 1966, 50 P.S. §§ 4101 *et seq.* Nor can the concept of a least restrictive

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[3] The court noted that the district court predicated its least restrictive environment holding "exclusively upon constitutional grounds." Jt. App. 130a.

alternative be found in the Pennsylvania statute. On the contrary, the Pennsylvania statute plainly contemplates a bifurcated mental retardation services delivery system, in which the state, through its system of regional institutions, would provide long-term residential placements, and the counties would provide short-term residential services. *See, e.g.*, 50 P.S. §§ 4201, 4202(a), 4301(a) and (d). Moreover, Pennsylvania did not even begin moving people into Community Living Arrangements until 1972, six years after enactment of the Act. Although mental retardation programs are generally funded 90 percent by Pennsylvania and 10 percent by the counties, the Community Living Arrangements program has been funded 100 percent by Pennsylvania, since it is a "new program" established by the Pennsylvania Department of Public Welfare. *See* 50 P.S. § 4507. Thus, to suggest that Pennsylvania law establishes a presumption in favor of placement in Community Living Arrangements, PARC Br. at 7, 19, is to read into the Act a requirement that it does not contain, and that is plainly contrary to the structure of the mental retardation services delivery system contemplated by the Act. Such a suggestion also ignores the history of the development of Community Living Arrangements in Pennsylvania.[4]

II. In addition, the PARC Respondents (but not the Halderman Respondents) present the novel claim that this Court need not consider whether the DD Act creates

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[4] *In Re Guzan*, —— Pa. Cmwlth. Ct. ——, 405 A.2d 1036, 1038 (1979), relied upon by the PARC Respondents, Br. at 21, is inapposite and its holding is misstated. First, *Guzan* discussed a constitutional right to treatment, not one grounded on the state statute. More significantly, the decision does not support the presumption against institutional care. To the contrary, it approved a transfer to a state-operated institution, merely recognizing that the state statute required a hearing before transfer.

a private right of action because "this is a § 1983 case," PARC Br. at 29. In essence, PARC maintains that the DD Act is a statute "providing for equal rights" and that all such statutes are "laws" within the ambit of 42 U.S.C. § 1983, thereby creating independent federal jurisdiction under 28 U.S.C. § 1343. This argument, never pressed below, seems plainly incorrect and, in any event, is beside the point. The decision of the Court of Appeals was based firmly on the DD Act and its supposed far-reaching effects. Nothing in PARC's § 1983 argument detracts from the certworthiness of that decision.

Initially, we note that the issue concerning which "laws" are within the scope of § 1983's coverage is currently before this Court in *Maine* v. *Thiboutot*, 405 A.2d 230 (Me. 1979), *cert. granted*, No. 79-834, 48 U.S.L.W. 3465 (January 21, 1980). While it would be fruitless to anticipate the outcome of that case, it nevertheless seems clear that PARC's attempt to invoke § 1983 in this case is misguided. As was pointed out in several of the petitions, the question of whether the DD Act implies a private right of action turns in large part on whether Congress intended to create legally-enforceable *rights* for developmentally disabled persons or whether it was enacting a funding statute that set certain general *goals* for the recipient states. If, as petitioners believe, the latter view is proper, the DD Act would not then be a statute "providing for equal rights," and PARC's § 1983 claim would be plainly inapt. In any case, the petitions in this case clearly should not be denied while *Thiboutot* is pending.

More significantly, even if § 1983 is found to create a private right of action to enforce the DD Act, this case still raises critical issues about the scope of the Act and the appropriateness of the massive relief ordered below. These were the sole issues raised in the dissenting

opinion below and they remain at the heart of the disposition by the Court of Appeals. Petitioners believe that no reasonable reading of the Act justifies a federal court in restructuring a state system of mental retardation care, empowering a master to decide the appropriate placement for each of 1200 people, and ordering the state and local governments to expend resources to construct new facilities.[5] At a minimum, such a radical result requires review by this Court.

CONCLUSION

Pennsylvania law does not independently support the decision of which review is here sought. Nor does 42 U.S.C. § 1983 furnish a ground on which this Court can sustain the decision below. Rather, that decision rests squarely upon a novel interpretation of a federal funding statute. There is no question that the issue presented here is important. As the Petitions and the Briefs of the *Amici Curiae*[6] demonstrate, this case touches a vital interest of all the states, affecting billions of dollars annually of states' funds, and hundreds of thousands

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[5] Indeed, a recent decision of a federal district court in Kentucky explicitly supports petitioners' position that the DD Act does not prevent a state from choosing to commit its resources to institutional care of the mentally retarded. *Kentucky Ass'n for Retarded Citizens* v. *Conn*, Civ. No. C 78-0157 L(A) (W.D.Ky. March 21, 1980) (Allen, C.J.). Registering its disagreement with the opinion of the Court of Appeals in this case, the court in *Conn* stated its belief that in the DD Act, "Congress . . . left it to the states to decide the proper allocation of funds and did not authorize federal courts to dictate how those funds were to be spent by the states." Slip op. at 20. A copy of that opinion is attached as an Appendix hereto.

[6] Connecticut, New York, Illinois, Washington, New Hampshire and West Virginia.

of mentally disabled people. Review by this Court is thus warranted and should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY
AT LOUISVILLE

Civil Action No. C 78-0157 L(A)

KENTUCKY ASSOCIATION FOR RETARDED CITIZENS, *et al.*,
Plaintiffs,

UNITED STATES OF AMERICA,
Litigating Amicus Curiae,

v.

PETER CONN, Secretary, Kentucky Department for Human Resources, *et al.*,
Defendants.

JUDITH ANN LINTON, DAVID BRENT HARRALSON,
Intervening Defendants,

CHARLES W. DOBBINS, JR.,
Guardian ad litem.

JUDGMENT

This action, having been submitted to the Court for decision following a trial before the Court, without a jury, and the Court, having considered the papers on file, the testimony of the witnesses, the briefs of the parties, the amici curiae, the oral arguments of the parties, and one amicus curiae of the National Juvenile Law Center, Inc., and the Court, having filed its findings of facts, conclusions of law and memorandum opinion, and being fully advised in the premises,

IT IS ORDERED AND ADJUDGED as follows:

1. So much of plaintiffs' complaint as seeks to prevent construction of a new Outwood facility at Dawson Springs, Kentucky, for the mentally retarded is hereby dismissed with prejudice.

2. The defendants, their servants, agents, employees and persons acting in privity with them are hereby permanently enjoined from placing in the present Outwood facility or in the new facility which will be constructed at Outwood for the care of the mentally retarded any status offenders or persons convicted of criminal offenses.

3. The defendants, their servants, agents, employees and persons acting in privity with them are hereby enjoined from placing in the present Outwood or in the Outwood facility to be constructed any mentally retarded persons who are either mildly or moderately retarded for any period longer than 30 days.

4. The Court specifically declares that each resident at the present Outwood or each resident who will be confined at the new Outwood shall be considered to be involuntarily committed, with the exception of those adult individuals who have acted on their own and without the auspices of a guardian or committee in applying to and securing admission to the mental retardation residential treatment center. As to these persons who are considered to be voluntarily confined, it is declared that K.R.S. 202B.040 is not applicable and said persons are entitled to be discharged forthwith upon their application for discharge.

It is further declared that every resident who has been committed by a guardian or committee has the same right as do minors to seek relief from actions approved by their guardians or committees for or against admission and discharge.

It is further declared that as to those persons who have voluntarily admitted themselves to the mental retardation residential treatment center, they are entitled to all of the rights set out in K.R.S. Chapter 202B provided, however, that K.R.S. 202B.040 and 202B.060(9) are not applicable to them since they are entitled to immediate relief upon their own application.

It is further declared that each resident committed by the action of a guardian or committee is entitled to the rights set out in K.R.S. 202B.040 and 202B.060, to the least restrictive alternative mode of treatment and to release from the mental retardation residential treatment center, where a determination is made by the interdisciplinary team that he or she presents no immediate danger or immediate threat of danger to self or others, and where the least restrictive alternative mode of treatment is in a community living facility, and where there is in existence a community facility which can adequately treat and supervise the resident.

It is further declared that each involuntarily confined resident may have the same rights as those conferred upon minors who are residents to seek relief from actions approved by their guardians or committees for or against admission and discharge.

It is further declared that every mentally retarded resident now at Outwood, or who will be at the new Outwood, or who will be at the old Outwood pending construction of the new Outwood, is entitled to the rights set out in the minimum standards in 42 U.S.C. Sec. 6010(3)(A) and (B).

It is further declared that all mentally retarded residents now in the facilities at Outwood or who, in the future, will be at such facilities, or at the new Outwood shall have all of the rights specifically set out in K.R.S. 202B.060(1) through (8) and (10) through (13).

IT IS FURTHER ORDERED AND ADJUDGED that when an interdisciplinary team reaches the conclusion that a resident at the present Outwood or the new Outwood facility has the potential for placement in an alternative living arrangement within two years, that such decision, along with a description of the requirements of the alternative for that resident, shall be conveyed forthwith to the Secretary of the Department for Human Resources.

IT IS FURTHER ORDERED AND ADJUDGED that the Secretary for Human Resources, upon receiving such communication, shall make inquiry as to what community living arrangement facilities are available for the placement of the resident and the distribution of beds which are available for use by mentally retarded persons, giving priority to those persons found by the interdisciplinary team to be capable of being cared for in such community arrangements.

IT IS FURTHER ORDERED AND ADJUDGED that Charles W. Dobbins, Jr. Guardian ad litem, present to the Court his request for a reasonable fee to be awarded him, together with a summary of the hours which he has expended in connection with this action; said request to be filed within 15 days after entry of this judgment.

IT IS FURTHER ORDERED AND ADJUDGED that counsel for plaintiffs shall, if they so desire, move the Court for attorneys' fees, said motion to be accompanied by a detailed summary of the time expended on this action, together with a description as to whether they are lawyers or paralegal, said memoranda to be filed 20 days thereafter.

IT IS FURTHER ORDERED AND ADJUDGED that the parties to this action, with the exception of the United States, shall bear the costs of this action equally.

This is not a final and appealable judgment.

Dated 3/21/80

/s/ Charles M. Allen
CHARLES M. ALLEN
Chief Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF KENTUCKY
AT LOUISVILLE

Civil Action No. C 78-0157 L(A)

KENTUCKY ASSOCIATION FOR RETARDED CITIZENS, *et al.*,
Plaintiffs,

UNITED STATES OF AMERICA,
Litigating Amicus Curiae,

v.

PETER CONN, Secretary, Kentucky Department
for Human Resources, *et al.*,
Defendants.

JUDITH ANNE LINTON, DAVID BRENT HARRALSON,
Intervening Defendants,

CHARLES W. DOBBINS, JR.,
Guardian ad litem.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND MEMORANDUM OPINION

This action is submitted to the Court for a decision following a non-jury trial which lasted some 31 days, and which resulted in more than 5,000 pages of testimony, together with numerous depositions and hundreds of exhibits.

The complaint was filed on May 16, 1977 by the Kentucky Association for Retarded Citizens, hereinafter KARC, and six retarded current and former residents of Outwood and their parents or guardians. A class action order was entered by the Court allowing the plaintiffs to represent all persons who presently reside

or may, in the future, reside at Outwood. Outwood is a 300 bed residential facility for retarded persons, located in a rural setting a few miles from Dawson Springs, Kentucky, a city of approximately 3,000. Outwood is operated by defendant Excepticon, Inc., a private corporation under contract with the defendant Department for Human Resources of the Commonwealth of Kentucky. Defendant Peter Conn is the Secretary of the Department for Human Resources, and the other defendants are William P. McElwain, Commissioner, Kentucky Bureau for Health Services; Jack C. Lewis, Commissioner, Kentucky Bureau for Social Services; the Director, Kentucky Division for Mental Health and Mental Retardation Services; Russell McClure, Commissioner, Kentucky Executive Department for Finance and Administration; Clayton Lorenzen, Facility Director, Excepticon-Outwood Campus; Excepticon, Inc., a Kentucky Corporation; Maxine Pulliam, Guardianship Officer, Kentucky Department for Human Resources.

In addition, the parents of Outwood residents Judith Anne Linton and David Brent Harralson have intervened on behalf of their children in favor of an institution such as Outwood. The United States of America has intervened, litigating amicus curiae, and has allied itself with the plaintiffs. Charles W. Dobbins, Jr. has been appointed Guardian ad litem, to protect the interest of the class.

The plaintiffs' action alleges violations by the defendants of constitutional and statutory rights of the class represented by the plaintiffs. The action seeks to prevent the defendants from constructing a new facility at Outwood which would accommodate 175 mentally retarded citizens in 16 cottage-like residences.

Outwood has been the subject of many visits by witnesses of all parties, as well as the Guardian ad litem,

Charles W. Dobbins, Jr., who has been there on two occasions, the latter of which was on October 22, 1979 in the company of Dr. Joy Donaldson, Mr. Jerry Griepentrog, and the Court.

Outwood was originally constructed in 1922 for the treatment of victims of respiratory illnesses, primarily tuberculosis. In 1962, it was turned over to the State of Kentucky and used by it as a facility for the mentally retarded until 1975, when it entered into a contract with Excepticon, Inc. to operate the facility for a fixed fee. That fee was $4,951,840 for the year ending January 31, 1979, paid in quarterly installments with provisions for a return to the State of Kentucky of substantially all of any profits in excess of 10% of the contract amount.

The new facility envisioned by the defendants would cost in excess of $8,000,000 to build and would be located virtually in the same place as the present one. All of the witnesses agree that the new facility will be a great physical improvement over the present one, which has been described as "atrocious" by witnesses for all of the parties.

Plaintiffs contend that construction of the new facility, as opposed to development of community alternatives, is in violation of 29 U.S.C. Sec. 794 and 42 U.S.C. Sec. 6010, et seq., as well as K.R.S. Chapters 202 and 210, under a claim of right to treatment, right to the least restrictive alternative, and right to freedom from harm. Plaintiffs also claim violation of the Fourteenth Amendment by denial of the rights to treatment and the least restrictive alternative, right to freedom from harm, and denial of equal protection, and violation of the Eighth Amendment's right to freedom from harm.

Defendants generally maintain that many of these claims have no legal standing in this Court and further that even if the amendments to the Constitution and

statutes cited by plaintiff are applicable, that there has been no violation of their rights.

There are now approximately 266 residents at Outwood, of whom 54% are profoundly retarded, 33% are severely retarded, 12% are moderately retarded, and 1% are mildly retarded. The American Association on Mental Deficiency classes the profoundly retarded as having an I.Q. of 0 to 19, the severely retarded as having an I.Q. level of 20-35, the moderately retarded as having an I.Q. level of 36-51, and the mildly retarded as having an I.Q. level of 52-67.

Defendants contend that a profoundly retarded person can function only at a level equivalent to a 2 to 12 month old child, and that a severely retarded person can function at a level of a normal child between the ages of 12 months and three years. Plaintiffs take the position that, although profoundly retarded persons may never be completely independent, they are entitled to reside in group community homes or other facilities which are not of an institutional nature, and that it is in these facilities, as opposed to instructions, that the maximum potential of the person can be realized.

The record is replete with statements by plaintiffs' witnesses praising the group home concept and denouncing the institutional concept. These witnesses point to the advances being made in states such as New York, Massachusetts, Nebraska, Kansas, and Pennsylvania where many mentally retarded persons are being deinstitutionalized, either as a result of a consent decree, or as a result of a change in the philosophy of the state in question.

The defendants contend that, although it is desirable for the mentally retarded to be placed in that environment which is the most home-like that can be afforded, that there do not exist in Kentucky sufficient group homes and facilities to take care of the mentally retarded who

could utilize them. They further argue that it will always be desirable to have centrally located regional facilities which offer all types of services that are needed by the mentally retarded and which will act as learning centers for those engaged in the treatment and care of the mentally retarded.

Although the witnesses for the plaintiffs were almost unanimous in their opinion that the severely and profoundly retarded persons could be placed in community settings, such as group homes, and although the trend nationally is toward such development, all of them conceded that in each of the states where they resided institutional facilities were still in use, and that in the great majority of instances, such institutions were much larger than the proposed new Outwood. It also seems to be the consensus of opinion of all the witnesses that it is inappropriate to deinstitutionalize mentally retarded residents until all of the necessary support services, group homes and other residential facilities have been provided in the communities to which the individuals are to be released.

Broadly stated, the plaintiffs' position seems to be that it is the duty of the State to provide all of the group homes and other residential facilities, and the support services in all of the communities where mentally retarded persons would be expected to live. Plaintiffs believe that it would be a waste of funds to expend the eight million or more dollars which would be required to build the new Outwood when such funds could be diverted to provide residential care facilities.

Plaintiffs proposed some 397 findings of fact. Defendants took issue with a great many of these proposed findings. At this stage of the opinion, it should be observed generally that plaintiffs' complaints cover almost the complete range of services provided by Outwood.

Plaintiffs introduced witnesses for the purpose of showing that Outwood has failed to provide a minimal opportunity for habilitative care of its residents, that it has been plagued with staff shortages, high turnover, inadequate and insufficient employee training programs which have harmed the residents, that it has abused the residents and injured some of them, and has failed to provide adequate programs to stimulate the potential of the residents. Broad sweeping statements are made that the psychological and social services, the occupational therapy services, the speech services, dietary services, therapeutic recreation services, physical therapy services, and medical, drug and nursing services at Outwood are inadequate.

Plaintiffs contend further that the Outwood residents are involuntarily confined and are denied meaningful participation in the activities of community life. Plaintiffs also argue that even though the proposed 176-bed facility with its 11 homelike cottages, each containing 16 residents, would be a great physical improvement over the present facilities, there is no need for the proposed facility and that all of the services which it would provide can be provided in the community.

The contention has been made that there is no showing that Outwood will provide the least restrictive alternative for persons proposed to be placed there, and that the New Directions program formulated in 1979 by the State does not show a need for the new Outwood, nor assure access to community placements for inappropriately institutionalized residents, and precludes certain retarded persons from placement in community settings solely on the basis of their handicap. The argument is further made that federal funds are available to finance services in the community and that these services will cost less than a new Outwood and the services to be provided there.

The further argument is made that Outwood is segregated and isolated, and that by reason of its location, there have been chronic shortages in staff, a lack of effective community assimilation, and that the decision to build the new Outwood is inconsistent with recommendations that the old facility be closed and be replaced. Plaintiffs also contend that there are numerous reports of Kentucky executive and legislative branches, as well as the Department for Human Resources, which recognize that the normalization principle mandates the development of community-based residential services for retarded persons.

The evidence produced by the parties on a great many of the issues raised by the plaintiffs was sharply conflicting. For example, there were parents who testified that they believed that Outwood was not a desirable place to keep their mentally retarded children, while there were other parents who testified that Outwood was a desirable place to maintain their mentally retarded children. Those testifying parents who had withdrawn their children from Outwood had placed them in institutions such as Cedar Lake Lodge, a 60-bed facility operated by a religious organization; that particular institution is far more updated and pleasing in its physical appearance than the present Outwood, and is constructed using the cottage arrangement proposed for the new Outwood. These parents had not placed their children in group homes, according to their testimony, because no such facility was available, and it was not possible for the children to return home to live with their parents.

When the evidence is fairly weighed and the credibility of the witnesses duly assessed, the following findings seem appropriate:

Plaintiffs failed to show any physical abuse of any Outwood resident with one exception which occurred in 1969.

Plaintiffs failed to show that excessive use of restraints is now occurring, although prior to the basic upgrading which took place at Outwood in 1977, and which followed the filing of this suit and the promulgation of state and federal regulations, restraints were excessively used and at times without adequate reasons. Prior to the filing of this suit and the promulgation of the regulations, there is little doubt that most of the rooms of the residents were bleak and sterile, and that little or no consideration had been given to providing a cheerful environment for the residents. That situation has been drastically changed, and probably the filing of this lawsuit, combined with the promulgation of the regulations, prompted Excepticon to purchase draperies and chairs, cabinets for the use of residents in placing their personal belongings, partitions for showers and toilets, and other physical improvements which otherwise would not have been made.

Plaintiffs produced as a witness Dr. Sprague, whose testimony was to the effect that a large percentage of the residents were receiving more than one psychotropic drug, a practice identified as polypharmacy. He also testified that drugs were being prescribed on a p.r.n. (as needed) basis, and that this was a dangerous practice. He also complained about the use of intramuscular injections of drugs, and that adequate training had not been offered to direct care staff as to the side-effects of psychotropics and neuroleptics.

The defendants produced evidence by Dr. Mason and Dr. Ruth, and after weighing the testimony of these witnesses and that of Dr. Sprague, the Court finds that as of the date of Dr. Ruth's testimony in 1979, only 7 out of 269 residents were receiving more than one psychotropic drug on a daily basis. The Court further finds that the use of intramuscular injections on a p.r.n. basis is not injurious to the residents where the need is medi-

cally identified and documented, and the circumstances under which the medication may be so administered are clearly described in the resident's record; the evidence showed that there was a limited use of such administrations.

The Court also finds that Dr. Sprague's testimony that excessive dosages of drugs were prescribed in the recent past is not convincing, and that the only proven instance of excessive drug dosage was that of a resident who was receiving 1,000 units of mellaril daily. The defects which existed in 1975 have been largely, if not entirely, remedied by a better system of recordkeeping, by more intensive training given to staff regarding the use of psychotropic drugs, and more importantly by the diminution in the use of psychotropic drugs.

It should also be observed that plaintiffs' attempt to prove that the deaths of Robert E. and Lawrence L. were caused by defendants was not sustained by the preponderance of the evidence. In the case of Robert E., the evidence shows that death occurred as a result of aspiration of food, and this accident occurred despite the fact that the resident was under close supervision in a feeding program at the time, and received immediate medical attention when the choking was observed. In the case of Lawrence L., plaintiffs attempted to show that death, immediately resulting from bilateral aspiration, was produced by an overdose of Sparine, administered intramuscularly pursuant to a p.r.n. order. The most that the evidence shows is that it is possible for extremely large doses of Sparine to suppress the cough reflex. This falls for short of proving that Sparine produced the tragic death of this resident.

In the area of adaptive equipment for mentally retarded residents who suffer orthopedic problems, it was shown that Excepticon was deliquent in providing the needed equipment promptly, but that it did, after a six

months delay, secure such equipment for those of its residents who were in need of it. There was little evidence which showed any substantial harm was done to any of the residents who had need of this orthopedic equipment, although it is obvious that such harm could result if the equipment were not available over long periods of time.

With regard to the question of whether residents are progressing or regressing, the evidence is quite conflicting. There was evidence that some residents' records reflect fewer skills now than at the time of their admissions. There was also testimony from some parents that their children can readily perform at home tasks which are still part of their allegedly unattained objectives at Outwood. On the other hand, there is substantial evidence of improvement on the part of some of the residents. As may be expected, the acquisition of learning skills and improvements in that field can be painfully slow. For example, in the past four years, Outwood has discharged only 77 of its residents; of these, 24 were released back to their own families, 20 to nursing or personal care homes, 17 to other ICF/MR facilities, and only 14 to group homes or other community placement. On the other hand, Excepticon contends that only 87 of the 269 persons presently residing at Outwood are expected to become residents of the new facility.

Prior to this lawsuit, interdisciplinary team assessments of the residents were not conducted on a systematic basis, and the plans for the treatment and training of the mentally retarded were vague and not in keeping with high standards of care. Since the filing of the lawsuit and the promulgation of state and federal regulations, interdisciplinary assessment is made of each resident at least annually. The parents of the resident, as well as the resident himself, are invited to this periodic review session. Comments and suggestions are made by

each member of the team and recommendations are made for changes in the resident care plan. The periodic review includes a statement of potential for alternative placement.

The evidence shows that Excepticon has plans to employ 364 persons. As of January 1, 1979, there were 12 positions which were unfilled:

One full-time psychologist; two licensed practical nurses; one program director; one cottage supervisor; two social workers, one physical therapist; and three direct care aides.

Of the 364 positions maintained by Excepticon, 88 are executive and administrative, food service, maintenance, and other non-direct care duties. The remaining 276 positions which are much more directly connected with the care of the residents are divided into 34 categories. In terms of numbers, the most significant positions are direct care aides, with 127 potential employees; institutional aides with 24 employees; health care aides with 22 employees; licensed practical nurses with 16 employees; medical technicians numbering 13; workshop aides and a position designated as "Ad Act" numbering 12. Another position to be noted is that of registered nurses, of whom there are 6; cottage supervisors numbering 7; social workers numbering 3; and unit directors numbering 3.

In addition, there are provisions for one or more physical therapists, laboratory technicians, a pharmacist, an x-ray consultant, a dental consultant, occupational and speech therapists, a psychologist, chaplains, a dietician, and a pre-sheltered vocational director.

Defendants do not dispute that Outwood has suffered staff turnovers as high as 88% to 100% per year, but point out that bare statistics reveal little concerning the actual staff composition, since the same position may have

turned over more than once in a year. More significantly, both defendants' and plaintiffs' witnesses testified that staff "burnout" and accompanying staff turnover are problems inherent in work with the mentally retarded, and can be observed in group homes and deinstitutionalized arrangements as well as in institutions.

Outwood has been without a full-time physical therapist since April, 1978, but has employed a full-time speech therapist and a psychologist. It is true that these employees, prior to their employment at Outwood, had had no experience in working with the mentally retarded. The psychologist was to become Board Certified in March, 1979.

During the course of the trial, and in their briefs, plaintiffs have pointed out that the ratio of staff to residents at Outwood did not in many areas meet the standards imposed by former District Judge Frank Johnson, now Circuit Judge on the United States Court of Appeals for the Fifth Circuit, in *Wyatt* v. *Stickney*, 344 F.Supp. 387 (W. D. Ala. 1972). Also, plaintiffs compared the ratio of staff at Outwood to that of the staff at the Pennhurst facility in Pennsylvania, which was the subject of a sweeping decree entered by District Judge Broderick in the case of *Halderman* v. *Pennhurst State School & Hospital*, 446 F.Supp. 1295 (E.D. Pa. 1977), aff'd. in part and rev'd. in part by the United States Court of Appeals for the Third Circuit, sitting *en banc*, —— F.2d ——, No. 78-1490, 1564, 1602 (Dec. 1979).

District Judge Broderick, in his opinion, compared the staffing at Pennhurst with the *Wyatt* v. *Stickney*, *supra*, standards, and in so doing, stated at p. 1303:

> "None of the standard reference sources now generally used by professionals in the field of mental retardation define the qualifications and minimal numbers of mental retardation professionals neces-

> sary to provide minimally adequate programs of habilitation."

However, the court in *Wyatt* v. *Stickney, supra,* attempted to provide such guidelines.

One further comment should be made in this area: Judge Johnson was faced with appalling conditions which existed at the Partlow State School and Hospital in Tuscaloosa, Alabama at the time when he made his decision. Faced with these conditions, which required drastic action, Judge Johnson rightfully took such action and imposed upon the Alabama authorities very strict standards with regard to the ratio of staff to residents. Since that time, it is the understanding of this Court that hearings have been held to determine whether the remedies prescribed by Judge Johnson originally should still be maintained, or whether there should be some relaxation of those very high standards which he set. That question has not been resolved.

This Court sits in a different circuit than did the *Wyatt* v. *Stickney, supra,* court and the *Halderman* v. *Pennhurst, supra,* court. These standards of ratio of staff to residents are, therefore, not binding on this Court. If the ratios of staff to residents accepted by Excepticon are adequate to meet the standards imposed by the licensing authorities, and there is no clear evidence that they do not meet these standards, then the ratios are within legal limits, unless plaintiffs can show that severe abuses have resulted as a result of failure to meet the *Wyatt* and *Halderman* ratios. The Court does not believe that plaintiffs have met this burden of proof.

Plaintiffs have shown that the average stay of the resident in Outwood is 9.9 years. Plaintiffs have shown that, although the State of Kentucky is now committed on paper to a program of placing mentally retarded persons in the least restrictive environment, and to putting

them into group homes and community settings, the performance by the State has not yet matched the promise. It also appears that the State has made its plans to construct the new facility without first determining on an individualized basis whether the needs of those persons who are now institutionalized would best be served by community placement or the building of a new facility.

One of the arguments made by the plaintiffs is that the eight million dollars or more which will be spent by the State in constructing the new facilities could be much better expended by providing community and group settings for mentally retarded persons. When one examines the cost of the new facilities, and the provisions made by the State for community facilities, the former cost dwarfs the expenditures to be made for the community facilities.

Plaintiffs and defendants produced witnesses who testified in general rather than specific terms regarding the relative costs of rendering necessary services to the mentally retarded person in a community living arrangement versus an institution. The testimony was conflicting, it was not based on any factors identifiable in Kentucky's specific situation, and while we are inclined to believe that costs would be irrelevant in any event, we must conclude that the testimony produced herein was not probative of any issue even arguably before us. This argument is basically one which, under ordinary circumstances, would be addressed to the Legislature and to the Department For Human Resources, and other parties charged with drafting and executing Kentucky's mental retardation laws.

Plaintiffs contend, however, that Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. Sec. 794, prohibits the State from building a new institution and from choos-

ing between institutions and placement in a community setting. This argument will be addressed first before considering the other statutory and constitutional claims of the plaintiffs.

Title 29 U.S.C. Sec. 794 provides:

> "No otherwise qualified handicapped individual in the United States, as defined in section 706(6) of this title, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance."

There is no question that mentally retarded persons are handicapped individuals within the meaning of the Act. See *Halderman* v. *Pennhurst*, *supra*, at p. 1323. Also, the State of Kentucky receives funds from the Federal Government which are used in the treatment of the mentally retarded of Kentucky and which are used to meet Kentucky's contractual obligation to Excepticon. Therefore, the statute is applicable to the mentally retarded residents located at Outwood. The question still remains as to whether the statute, either by clear implication or because of congressional language which preceded its passage, was meant to prohibit the states from institutionalizing the mentally retarded, or from providing facilities where mentally retarded persons could be housed.

It is clear that the statute on its face contains no reference to the building of new facilities for mentally retarded persons or any other handicapped persons. However, Judge Broderick, in holding that the statute had been violated in *Halderman*, *supra*, relied upon a statement made by Senator Hubert Humphrey on January 20, 1972, where the Senator called attention to three-fourths of this country's institutionalized mentally retarded, who

lived in facilities which were more than fifty years old, functionally inadequate and designed simply to isolate those persons from society. Senator Humphrey stated that these people have the right to live and to work to the best of their abilities but that they are too often kept out of our schools and community activities altogether because they are regarded as different or a disturbing influence. After asking what the cost-effectiveness was in consigning them to terminal care in an institution, he stated, "(T)hese are people who can and must be helped to help themselves." He went on to state that this was their constitutional right. See 118 Cong. Rec. 525 (1972) and *Halderman* v. *Pennhurst State School & Hospital*, *supra*, at p. 1323.

Judge Broderick, after discussing this eloquent statement by Senator Humphrey, went on to find that Section 504 confers a private right of action and imposes affirmative obligations on state and local governmental authorities, and that "under Section 504 unnecessarily separate and minimally inadequate services are discriminatory and unlawful," *citing Lloyd* v. *Regional Transportation Authorities*, 548 F.2d 1277 (7th Cir. 1977); *Barnes* v. *Converse College*, 436 F. Supp. 635 (D.S.C. filed July 12, 1977); *Gurmankin* v. *Costanzo*, 411 F.Supp. 982 (E.D. Pa. 1976), *aff'd*, 556 F.2d 184 (3rd Cir. 1977); 42 Fed.Reg. 22687 (1977); cf. *Lau* v. *Nichols*, 414 U.S. 563 (1974).

At the time that Judge Broderick decided *Halderman*, *supra*, he did not have the benefit of the Supreme Court decision in the case of *Southeastern Community College* v. *Davis*, 47 U.S.L.W. 4689, —— U.S. —— (1979). In that case the Supreme Court for the first time interpreted the Rehabilitation Act and specifically Section 504 of that Act. In that case, a woman who wished to become a nurse but who suffered severe hearing problems was denied admission to the Nurses' Training School

operated by the petitioner. The district court affirmed the decision of the college not to admit the respondent, but the Circuit Court of Appeals reversed and held that there was an affirmative obligation upon the part of the college to provide a program whereby the nurses' hearing handicaps could be minimized, and she could be trained to become a registered nurse. The Supreme Court reversed the appellate court decision and held that Section 504 of the Act does not impose an obligation upon an institution receiving federal funds to provide an affirmative action program for a person who is handicapped.

The language of Section 504 seems to this Court to be rather clear and straightforward. Its meaning is that a person who is qualified to perform a task or to enter an educational institution or to receive the benefits of any program or activity which receives federal financial assistance shall not be denied the right to work or to receive the benefits because he or she has a handicap. For example, an individual who is blind may not be denied the right to work in a facility that receives federal assistance if he is otherwise qualified to do the work. The handicap may not be used as an excuse to bar an individual from benefits of federal assistance, if the individual is otherwise qualified.

The *en banc* opinion of the United States Court of Appeals for the Third Circuit in *Halderman* v. *Pennhurst, supra,* of which 67 pages consisted of the majority opinion and 31 pages the dissenting opinion by Chief Judge Seitz (with whom Judges Aldisert and Hunter joined) approved nearly all of the actions taken by District Judge Broderick, but refused to rule upon the question of whether Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. sec. 794 (1976) reflected the Congressional desire to discourage the institutionalization of the mentally handicapped. Instead the court based its

decision on two basic grounds: The first was the premise that the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. Secs. 6000-6081 (1976) provided the right to treatment in the least restrictive alternatives for the mentally retarded, and further that it created a presumption that the least restrictive alternative for the mentally retarded is in community living facilities and not in institutions. The second premise was that Pennsylvania's Mental Health and Mental Retardation Act of 1966, Pa. Stat. Ann. Tit. 50 Secs. 4101-4704 (Purdon 1969), creates for retarded persons an affirmative right to minimally adequate habilitation.

While the majority opinion did not discuss or rule upon the meaning of the Rehabilitation Act of 1973, the dissenting opinion did, and correctly, in this Court's mind, reached the conclusion that Section 504 of that Act does not include a legislative mandate for deinstitutionalization. See the dissenting opinion, page 76. As the dissent points out, the purpose of the Rehabilitation Act was to prevent a state from discriminating against the participation of an otherwise qualified handicapped individual in any program or activity receiving federal aid, and also to prevent the states from denying such an individual the benefits of or subjecting him to any discrimination under a federally assisted program.

We must now consider the question, although it was barely raised by the plaintiffs initially, as to whether or not the Developmentally Disabled Act, hereinafter referred to as the DDA, constitutes a prohibition against the expenditure of state funds and federal funds for a new facility for the mentally retarded. The key section to the understanding of the bill is the so-called "Bill of Rights" section, 42 U.S.C. Sec. 6010. That section is as follows:

> "Congressional findings respecting rights of developmentally disabled.

"Congress makes the following findings respect[ing] the right[s] of persons with developmental disabilities:

(1) Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities.

(2) The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.

(3) The Federal Government and the States both have an obligation to assure that public funds are not provided to any institution or other residential program for persons with developmental disabilities that—

(A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons; or

(B) does not meet the following minimum standards:

(i) Provision of a nourishing, well-balanced daily diet to the persons with developmental disabilities being served by the program.

(ii) Provision to such persons of appropriate and sufficient medical and dental services.

(iii) Prohibition of the use of physical restraint on such persons unless absolutely necessary and prohibition of the use of such restraint as a punishment or as a substitute for a habilitation program.

(iv) Prohibition [of] the excessive use of chemical restraints on such persons and the use of such restraints as punishment or as a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation for such persons.

(v) Permission for close relatives of such persons to visit them at reasonable hours without prior notice.

(vi) Compliance with adequate fire and safety standards as may be promulgated by the Secretary.

(4) All programs for persons with developmental disabilities should meet standards which are designed to assure the most favorable possible outcome for those served, and—

(A) in the case of residential programs serving persons in need of comprehensive health-related, habilitative, or rehabilitative services, which are at least equivalent to those standards applicable to intermediate care facilities for the mentally retarded promulgated in regulations of the Secretary on January 17, 1974 (39 Fed. Reg. pt. II), as appropriate when taking into account the size of the institutions and the service delivery arrangements of the facilities of the programs.

(B) in the case of other residential programs for persons with the developmental disabilities, which assure that care is appropriate to the needs of the persons being served by such programs, assure that the persons admitted to facilities of such programs are persons whose needs can be met through services provided by

> such facilities, and assure that the facilities under such programs provide for the humane care of the residents of the facilities, are sanitary, and protect their rights; and
>
> (C) in the case of nonresidential programs, which assure the care provided by such programs is appropriate to the persons served by the programs."

The following observations are pertinent:

Congress, in enacting 42 U.S.C. Sec. 6010(1) and (2), seemed to be explicit in its finding that persons with developmental disabilities have a right to appropriate treatment and habilitation for those disabilities, and that the treatment and habilitation should be designed to maximize the developmental potential of the person in the setting that is least restrictive of his personal living. However, 42 U.S.C. Sec. 6010(3) qualifies or makes more specific the obligations of the federal government and the state, and, in essence, requires them to make certain that public funds do not flow to any institution or other residential program for the mentally retarded that either does not provide treatment and habilitation appropriate to the needs of such persons, or does not meet six specific minimum standards.

When paragraphs (1), (2) and (3) of 42 U.S.C. Sec. 6010 are fully examined, it seems fair to state that Congress contemplated that institutional as well as residential programs for the handicapped would continue to be provided, and, further, that the programs which are provided must either provide appropriate treatment and habilitation or meet the six standards referred to in paragraphs (3)(B)(i) through (vi).

Read in this manner, it is far from apparent that Congress was mandating the discontinuance of institu-

tional programs. On the contrary, it would seem that Congress realized that there might even be situations where a developmentally disabled person would not have to be furnished treatment and habilitation as such, but would have to be provided with custodial care according to minimum standards such as proper diet, appropriate medical services, proper safety compliance, and prohibition of the use of physical restraint.

This Court must respectfully disagree with the holding of the majority in *Halderman* v. *Pennhurst*, *supra*, with reference to the DDA. As Chief Judge Seitz points out at page 72, the legislative history of the 1975 amendments to the Act show a clear preference for deinstitutionalization. The amendments increased the authorization of appropriations for this purpose, and the House Report stated that the Committee hoped that State and other funds being spent on institutional care would be re-budgeted for community care, which had not always occurred. However, the House Conference Report reflects that the Committee chose to include a requirement that the State plan contain a plan to eliminate *inappropriate* institutionalization while improving the quality of care and surroundings for persons for whom institutional care is appropriate, and specifically rejected a Senate proposal to require a specific goal-oriented plan for deinstitutionalization. 1975 U.S. Code Cong'l and Admin. News 919, 953.

This Court believes that while Congress hoped for an approach by the states which would prefer community treatment to institutional treatment, there is no section in the DDA which mandates deinstitutionalization *per se*. Congress still left it to the states to decide the proper allocation of funds and did not authorize federal courts to dictate how those funds were to be spent by the states.

It is of some significance that the DDA was passed in 1975, after the decision of the Supreme Court in

O'Connor v. *Donaldson*, 422 U.S. 563 (1975). In that case, the Supreme Court specifically refused to pass upon the question of whether a mentally disabled person has a right to treatment when he is placed in a state institution against his will. The court avoided the issue by holding that the only issue was whether plaintiff had been deprived of his liberty without just cause. The court, therefore, refused to endorse any right to treatment theory, even though that right has been endorsed by many district and appellate courts. See *Wyatt* v. *Stickney*, *supra*, (aff'd. in part, remanded in part, reversed in part), *Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *Welsch* v. *Likins*, 373 F.Supp. 487 (D.Minn. 1974) aff'd in part and vacated and remanded in part, 550 F.2d 1122 (8th Cir. 1977); *Gary W.* v. *Louisiana*, 437 F.Supp. 1209, 1217-19 (E.D. La. 1976).

By way of summary, the Court holds that defendants have at least met the minimum standards prescribed in 42 U.S.C. Sec. 6010(3)(B)(i) through (vi), despite the fact that deficiencies may have existed with regard to excessive use of physical restraints and excessive use of chemical restraints prior to the implementation of the program of care which now exists at Outwood under the leadership of Excepticon. Whether these improvements have been due to the institution of the lawsuit or to Excepticon's management or the promulgation of federal and state regulations or to all of these factors cannot be determined precisely, but suffice it to say that the Court is satisfied that at least the minimum standards set out in the DDA are being met.

Although the DDA does not prohibit the construction of a new Outwood intended to house the profoundly and severely retarded, language contained in the Act, to wit: 42 U.S.C. Sec. 6010(b)(3)(B)(iii) by implication bans the contemplated placement of 32 mentally retarded offenders. That provision of the statute prohibits the use

of physical restraint on mentally retarded persons unless absolutely necessary, and the prohibition of restraints as punishment or a substitute for a habilitation program. The conclusion cannot be escaped that if mentally retarded persons who have been convicted of offenses are placed in the new Outwood, security measures involving the use of personnel who will partake somewhat of the character of prison guards will be necessary and probably other measures such as the locking of doors and facilities, as well as the possible use of barred windows may become necessary.

It is contemplated that these offenders, although living in separate cottages from other residents, would be in training modules, at parties for the residents, and quite possibly in vocational training, and the workshop, as well as participating in trips to the community. It would seem that the presence of mentally retarded offenders on the campus would greatly contribute to an atmosphere which was more in keeping with a penal institution than with a residential treatment center for the mentally retarded.

Also, it should be noted that the conditions that would probably be created by the treatment of mentally retarded offenders at the new Outwood would not be in accord with the findings made by Congress that treatment and habilitation for a mentally retarded person should be provided in a setting that is less restrictive of that person's personal liberty. While, as noted before, that finding is not binding upon the State, when it is considered in connection with the minimum standard pertaining to the use of physical restraint, it is sufficient to warrant the conclusion that the State should not house the mentally retarded offenders in a residential treatment facility.

This conclusion is not reached without some reluctance, since the Court is aware of the dangers implicit in placing a mentally retarded person in a prison or peniten-

tiary. To do so would subject him or her to almost certain abuse at the hands of his or her fellow inmates. Certainly the State can make better provisions for this class of persons than to resort to the alternative of a penitentiary or prison, and some type of group setting which is well secured should be the answer.

Even if the DDA is not applicable to mentally retarded offenders and does not prohibit their housing at a residential treatment center such as the new Outwood, there is no doubt that 42 U.S.C. Sec. 5633 prohibits the placement of status offenders who are mentally retarded at such a facility. The applicable portions of that statute are as follows:

> "(a) In order to receive formula grants under this part, a State shall submit a plan for carrying out its purposes consistent with the provisions of section 3733(a)(1), (3), (5), (6), (8), (10), (11), (12), (15), and (17) of this title. In accordance with regulations established under this subchapter, such plan must—
>
> . . .
>
> "(12)(A) provide within three years after submission of the initial plan that juveniles who are charged with or who have committed offenses that would not be criminal if committed by an adult, or such nonoffenders as dependent or neglected children, shall not be placed in juvenile detention or correctional facilities; and
>
> (B) provide that the State shall submit annual reports to the Associate Administrator containing a review of the progress made by the State to achieve the deinstitutionalization of juveniles described in subparagraph (A) and a review of the progress made by the State to provide that such juveniles, if placed in facilities, are placed in fa-

> cilities which (i) are the least restrictive alternatives appropriate to the needs of the child and the community; (ii) are in reasonable proximity to the family and the home communities of such juveniles; and (iii) provide the services described in section 5603(1) of this title;
>
> "(13) provide that juveniles alleged to be or found to be delinquent and youths within the purview of paragraph (12) shall not be detained or confined in any institution in which they have regular contact with adult persons incarcerated because they have been convicted of a crime or are awaiting trial on criminal charges[.]"

It is established by the evidence that the Commonwealth of Kentucky has been receiving funds from the United States under the Juvenile Justice Program and under the terms of 42 U.S.C. Sec. 5610 for more than three years and, therefore, the statute is applicable and is an absolute bar to the placement of status offenders at the new Outwood.

We now address the question of whether or not state law forbids the construction of the new Outwood, and if it does not, what are the rights of those persons who will be residents of the new Outwood, or who are now residents of the present Outwood.

K.R.S. 202B, effective June 17, 1976, is in effect a statutory bill of rights for the mentally retarded. K.R.S. 202B.060 is entitled "Rights of mentally retarded; secretary to adopt regulations. That statute goes on to provide, in substance, that the Secretary of Human Resources shall adopt rules and regulations for the proper administration and enforcement of Chapter 202B, which rules and regulations shall include but not be limited to the rights of mentally retarded residents in thirteen different areas.

K.R.S. 202B.010 defines a resident as a person under care or treatment in a mental retardation residential treatment center, and since that term means a residential treatment facility approved by the Department for the evaluation, care and treatment of mentally retarded persons, and since the new Outwood is approved by the Secretary of Human Resources for such problems, and since there is no prohibition in the statute against the construction of new facilities, the Court must conclude that Kentucky has not banned the construction of new facilities for the treatment and care of mentally retarded persons. On the other hand, Kentucky is very concerned, as evidenced by K.R.S. Chapter 202B, with the rights of those mentally retarded persons who are confined in mental retardation treatment centers such as the present Outwood or the new Outwood.

Insofar as the rights of the mentally retarded residents who are at the present facility and who would be at the new Outwood are concerned, an analysis of K.R.S. 202B.040 combined with 202B.060 reveals the intention of the Legislature to provide the least restrictive alternative mode of treatment for the mentally retarded.

In reaching this conclusion, the Court notes first that K.R.S. 202B.040 explicitly provides that before any person who is mentally retarded may be involuntarily committed, there must be a determination that he is a mentally retarded person and that he represents an immediate danger or an immediate threat of danger to himself or others and that the least restrictive alternative mode of treatment requires placement in a hospital or a mental retardation residential treatment center, hereinafter M.R.R.T.C., and that treatment which can reasonably benefit him is available in the hospital or M.R.R.T.C.

K.R.S. 202B.060, after setting out in its first ten sections the requirement that the Secretary of Human Resources shall adopt rules for the proper enforcement

of Chapter 202B, which shall include many rights of residents set out in 202B.060(1) through (11), then goes on to provide in subsection (12) for the release of residents to less restrictive alternative modes of treatment on convalescent status, and in subsection (13) requires the Secretary to make provisions for alternative methods of involuntary hospitalization.

While the language contained in K.R.S. 202B.060 tracks K.R.S. 202A.180, a statute which pertains to the rights of the mentally ill, that language plus the language contained in the following section for alternative methods for involuntary hospitalization, coupled with the sweeping language in K.R.S. 202B.040 as to the involuntary commitment, is ample evidence of the purpose of the Legislature to insure that mentally retarded persons who are involuntarily committed are not confined in an M.R.R.T.C. unless that is the least restrictive alternative mode of treatment. It would be incongruous, indeed, if a person could not be committed to an M.R.R.T.C. unless it was the least restrictive alternative mode of treatment, and then be confined there after it had developed that it was not the least restrictive alternative mode of treatment.

While the statutory scheme makes it clear that the involuntarily committed mentally retarded enjoy the right to the least restrictive mode of treatment, the question of who is involuntarily committed is not answered directly by the statutes. In the case at bar, it appears that there are three modes by which residents come to Outwood. The first is that it occurs when their guardian, usually a parent, determines to bring them to Outwood and placement has been made after approval by Excepticon. The second mode of commitment is that it occurs when an employee of the State, one Maxine Pulliam, is appointed as committee for a mentally retarded person and then makes application for his or her ad-

mission to Outwood, which is then approved by Excepticon. The third mode of admission is that it occurs when an adult mentally retarded person of his own volition requests admission to Outwood.

The evidence reveals that some 155 persons had been admitted to Outwood as a result of an application filed by defendant Maxine Pulliam. Four others were admitted as a result of an application by an adult mentally retarded person acting on his or her own behalf. The other 108, therefore, must have been admitted by applications filed by their guardians. The evidence did not show how many of the 155 who were committed under the auspices of Ms. Pulliam were committed by a court order. It should be observed that the evidence is not entirely clear as to the existing numerical composition of each of these classes of residents.

The defendants take the position that every resident at Outwood is voluntarily committed and has the right to seek his or her own discharge at any time, which right will be forthwith granted. This argument overlooks the obvious, to wit: the fact that the great majority of profoundly and severely mentally retarded persons are simply incapable of making decisions as to whether it is in their best interest to be placed in an M.R.R.T.C. or not. Particularly where a committee is appointed to represent them and that committee is a person such as Maxine Pulliam who has no personal relationship with her mentally retarded ward, there is compelling reason to find that the commitment of such wards is not a voluntary one. See *Halderman, supra,* at p. 19-20.

While the Legislature, in tracking as it did in K.R.S. Chapter 202B a great part of the language of Chapter 202A, may have addressed the problem of involuntary commitment in a manner which could suggest commitment only by court order, the use of the words "involuntary commitment" is ambiguous enough in the context of

the mentally retarded to allow the Court to place the interpretation it does on this statute.

The question of whether or not mentally retarded persons who are placed in Outwood by their guardians who are their parents or close relatives are involuntarily committed within the meaning of K.R.S. 202B.040 is a close one. From a practical point of view, those mentally retarded persons who are represented by guardians in the great majority will have no more meaningful contribution to make in the decision to place them in Outwood than do the mentally retarded who are represented by a committee. However, as suggested in *Parham* v. *J.L. and J.R., Minors, etc.*, No. 75-1690, 47 U.S.L.W. 4740 (decided June 20, 1979), although commitment of a mentally ill child represents a significant deprivation of his liberty, it is also to be presumed that the parent who places him in a mental institution is acting in his best welfare. That holding however does not transform the commitment by a guardian of a mentally retarded person from a voluntary to an involuntary commitment.

We are strengthened in our belief that such commitments are involuntary by the language of K.R.S. 202B.060(9) which gives residents who are minors the right to seek relief from actions approved by their parents or guardians for or against admission and discharge. While that statute did not give adult mentally retarded persons the specific right to seek such relief, it at least convinces this Court that the Legislature was aware that minors might, in fact, be involuntarily committed, either by their parents or guardians, and therefore gave them the right to seek relief either as to admission or discharge.

Summing up, we are of the opinion that all of the persons who are confined at Outwood or who will be confined at the new Outwood, with the exception of those

very few who have in fact made their own applications to be admitted, are entitled to the least restrictive alternative mode of treatment. Those few who are truly voluntary residents are not entitled to the least restrictive alternative mode of treatment but are entitled to release upon their own request.

Having set out the rights of the mentally retarded, we turn now to the remedies. First, it is noted that 13% of the now confined persons at Outwood are moderately or mildly retarded. The great weight of the opinion is to the effect that such persons can reasonably survive in an environment outside a M.R.R.T.C. Defendants have, in fact, indicated that such persons will not be confined at the new Outwood except for brief periods of respite care not to exceed 30 days. The Court holds as to those persons which it has defined as being involuntarily committed, and who are moderately or mildly retarded, that no right exists in Excepticon or the State defendants to hold such people in a M.R.R.T.C. The defendants must make a reasonable effort to see to it that these residents are placed in an environment outside the institution as soon as they are assured that the arrangements made for these persons are safe and will result in their continued habilitation.

Also to be observed is the fact that defendants have already determined that certain residents at Outwood are entitled to be placed in community living arrangements, but that decision cannot be executed because there are no adequate community living arrangements available. In this connection, defendants point to the fact that K.R.S. Chapter 210, and more particularly 210.370 through 210.480 grants the right to cities and counties to join in providing regional mental health programs which include rehabilitative services for patients suffering from mental retardation. See 210.410(6). The Sec-

retary of Human Resources is authorized to make grants to assist these regional mental health programs not to exceed 50% of certain expenditures, but no grants are to be made for capital expenditures. See 210.420.

Although the State has been slow in providing funds with which new beds may be made available for the mentally retarded in communities as opposed to institutions, it is apparent that steps are being taken to remedy the situation; 125 new beds were provided in 1979.

The remedy, it seems to the Court, as to those persons who are found by the interdisciplinary team to be capable of placement outside of Outwood or other M.R.R.T.C. is first to make certain these persons' needs for outside placement are communicated to the Department of Human Resources. Secondly, it appears to the Court that where Excepticon has informed the Secretary of Human Resources of the need for outside placement of a resident, then the Secretary should give priority to that resident as against the application of other mentally retarded persons who are in the community to be admitted to such facilities.

Finally, in construing K.R.S. Chapter 202B, the Court does not accept the contention of the plaintiffs that every profoundly and severely mentally retarded person is entitled to be placed in a community living facility. While this holding is implicit in the Court's previous holding that K.R.S. Chapter 202B is concerned with the rights of residents who are confined in M.R.R.T.C., the Court need only observe the least restrictive alternative modes of treatment for some profoundly and severely retarded persons may, indeed, be a M.R.R.T.C. Further, the Court observes that whether or not to place a person in such a facility and whether or not to continue his placement there is contingent upon the particular facts and circumstances surrounding that individual and his progress, and should be left to a decision-maker such as

the interdisciplinary team rather than in the hands of a court or court-appointed official. See the dissenting opinion of Chief Judge Seitz in *Halderman, supra,* at pp. 91-92 and by way of analogy the language of the Supreme Court in *Parham* v. *J.L. and P.R., Minors, etc., supra,* bearing on the question of admission of mentally ill juveniles.

While our analysis of K.R.S. Chapter 202B does do away with the need for a lengthy constitutional analysis, it is necessary to point out that K.R.S. 202B.060(9) would, if read in isolation, constitute a denial of equal protection to those residents who are not minors to seek relief from the actions approved by their committees or guardians for or against admission and discharge. However, we believe that in the light of the analysis which we have given K.R.S. Chapter 202B, there is no need to declare any portion of the statute unconstitutional, and that the rights of persons other than minors who are residents will be protected to the same extent as those of minors, with the exception of the truly voluntarily committed who have the right, as noted before, of securing their own discharge.

Two brief observations should be made. The first is that several courts have held that persons confined in an institution have a right to be free from physical abuse by employees or fellow confinees. There may also be a constitutional right to be free from serious injuries caused by assaults by fellow inmates where the injuries came about as a result of the failure of the defendants to exercise ordinary care to prevent such injuries. *Halderman, supra,* 446 F.Supp. at p. 1320; *Holt* v. *Sarver,* 300 F.Supp. 825 (E.D. Ark. 1969); *Holt* v. *Sarver,* 309 F.Supp. 362 (1970). We find no such violation on the facts before us.

We observe that Excepticon's argument that it is not subject to suit under 42 U.S.C. Sec. 1983 is without

merit. Where a private corporation undertakes to perform duties which have been largely within the province of the State, and wherein it receives substantial sums of money from the State for the performance of such duties, there exists a sufficient relationship between it and the State to make it a suable entity under 42 U.S.C. Sec. 1983. See *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715 (1961).

Title 42 U.S.C. Sec. 1988 provides in substance for the award of reasonable attorneys' fees to parties who have prevailed in actions brought under 42 U.S.C. Sec. 1983, et seq. Since the parties may wish to brief the question of whether or not plaintiffs' attorneys are entitled to fees in this case, and if so the amount thereof, the Court will grant plaintiffs 20 days hereinafter to brief this question and submit any affidavits pertaining to the time spent by them on the case, with the right of the defendants to respond within 20 days thereafter.

A judgment in accordance with these findings of fact, conclusions of law and memorandum opinion will be entered this day.

Dated 3/21/80

/s/ Charles M. Allen
CHARLES M. ALLEN
Chief Judge

Supreme Court, U. S.
FILED
MAY 3 1980
JR., CLERK

Supreme Court of the United States

OCTOBER TERM, 1979

NO. 79-1404

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,

Petitioners

v.

TERRI LEE HALDERMAN, et al.,

Respondents

BRIEF OF THE STATE OF CONNECTICUT AS AMICUS CURIAE IN SUPPORT OF THE GRANT OF CERTIORARI

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Third Circuit appears at 612 F.2d 84.

The opinion and order of the United States District Court for the Eastern District of Pennsylvania both appear at 446 F.Supp. 1295.

CONSENT OF THE PARTIES

Consent of the parties is not required since this brief of the State of Connecticut as Amicus Curiae is sponsored by its Attorney General. U.S. Sup. Ct. R. 42.

INTEREST OF AMICUS CURIAE

The State of Connecticut, as *parens patriae*, renders necessary services to its retarded citizens. A wide variety of services are offered, including evaluation and testing, counseling, respite care, special school districts, group homes, regional centers and state schools for the retarded. The demand for such services, however, exceeds the available resources, so that there are waiting lists for some of the services that are provided.

The court below broke new ground in federal-state relations concerning the care of the retarded in at least two respects:

1) By ruling that the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000, *et seq.* (hereinafter the "DD Act" or the "Act"), requires the states to render services to all of its developmentally disabled citizens, and

2) By requiring the services to be rendered in the least restrictive environment.

If the decision of the court below is affirmed, or followed by the remaining Circuits, the states will be required to provide services, regardless of cost, to all its developmentally disabled citizenry and in the manner that is mandated by the federal judiciary.

Connecticut, like all of the fifty states, participates in the DD Act program, receiving federal funds under the Act to render services in accordance with its state plan, which has been approved by the Department of Health, Education and Welfare (HEW). Only approximately Three Hundred Ninety-eight Thousand ($398,000) Dollars in federal monies was received under the Act for the fiscal year ended September 30, 1979. All of the monies received under the Act are utilized to provide community based services.[1]

STATEMENT OF THE CASE

This is a class action lawsuit, brought on behalf of all current and future residents of the Pennhurst State School and Hospital, alleging that the facility is operated in a manner that violates its mentally retarded residents' constitutional and statutory rights.

After an extensive trial, the District Court (Broderick, J.) found that the facility violated its residents' constitutional rights to "habilitation", *Halderman v. Pennhurst State School and Hospital*, 446 F.Supp. 1295, 1314, 1321 (E.D. Pa. 1977), as well as their statutory right to "nondiscriminatory habilitation" under Section 504 of the Rehabilitation Act, 29

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[1]The District Court in *Halderman* made no findings as to the DD Act. The Supplemental Memorandum of the Commonwealth of Pennsylvania before the Third Circuit Court of Appeals, dated August 15, 1979, p. 1-7, however, indicates that no DD Act funds are utilized at Pennhurst

U.S.C. §794. *id* at 1323. Rather than ordering that the facility be improved, the District Court ordered that the facility be closed and a master was appointed to supervise the transfer of residents into the community. *id* at 1325.

On appeal, the Third Circuit Court of Appeals largely affirmed the relief ordered below, but relied on an entirely different legal approach than the District Court. *Halderman v. Pennhurst State School and Hospital*, 612 F.2d 84 (3rd Cir. 1979). The majority ruled that Congress was legislating to implement the Fourteenth Amendment when it passed the DD Act, *id.* at 98, and that the Act provided the developmentally disabled with a right to habilitation, *id* at 95, which must be provided in the setting that is least restrictive to personal liberty, *id* at 107.

REASONS FOR GRANTING THE WRIT

I. The Act Was Not Passed Pursuant To Congress' Power to Implement The Fourteenth Amendment.

As noted, *supra*, the Court below held that the DD Act was passed pursuant to Congressional power to implement the Fourteenth Amendment.[2] The Court's conclusion is implicitly

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[2]The only support that the Court below offered for their conclusion that Congress intended to legislate pursuant to the Fourteenth Amendment is the remarks of two Senators, neither Chairman of the Subcommittee that introduced to legislation, as to Senate Bill 462. 612 F.2d fn. 17 at 98. The Bill subsequently went to conference where the "rights" provided by Senate Bill 462 were compromised. See, House Rep. 94-58, 94th Cong., 1st Sess. p. 41, 42, *reprinted in* 2 [1975], U.S. Code Cong. and Ad. News 919, 961, 962.

Even the remarks of the two individual Senators do not support a finding that the DD Act was enacted pursuant to Congress' power to implement the Fourteenth Amendment. Senator Stafford's remark is that, "Title II was added to the bill to assist in the protection of rights guaranteed under our Constitution . . ." 121 Cong. Rec. 16516 (1975). Senator Javits remarked that the federal government had abrogated its responsibility toward the developmentally disabled, citing *Wyatt v. Stickney*, and then noted that, "Congress should reaffirm its belief in equal rights for all citizens . . . This bill of rights of

based on cases holding that civilly committed mental patients and retardates have a quid pro quo "right to treatment".[3] See for example, *Wyatt v. Stickney*, 325 F.Supp. 781, *enforced*, 334 F. Supp. 1341 (1971), *supplemented*, 344 F.Supp. 373, 344 F.Supp. 387 (M.D. Ala. 1972), *aff'd in part, rev'd in part, remanded in part, sub nom. Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *Donaldson v. O'Connor*, 493 F.2d 507 (5th Cir. 1974), *vacated on other grounds and remanded*, 422 U.S. 563 (1975); *Gary W. v. Louisiana*, 437 F.Supp. 1209 (E.D. La. 1976).

This Court has not yet ruled on whether civilly committed patients have a right to treatment. In *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975), this Court narrowly ruled that, ". . . a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in freedom . . .". The right to treatment theory, however has been sharply criticized. Speece, *Preserving the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right to Treatment Theories*, 20 ARIZ. L. REV. 1 (1978); *O'Connor v. Donaldson*, *supra*, p. 2495-2500. (Burger, J.) (concurring opinion).

S.B. 462 represents this new direction, and begins this new reaffirmation." 121 Cong. Rec. 16519 (1975). "Assistance" or a "new reaffirmation" may indicate Congressional concern and a preference for deinstitutionalization, but hardly amounts to a federal mandate passed pursuant to the Fourteenth Amendment.

That conclusion is also inconsistent with the history of the Act, see House Rep. No. 94-58, *supra*, and the implementing HEW regulations which indicate that Act is a co-operative federal-state grant program.

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[3]Cases concerning the retarded have tended to blur the distinction between the civil committment of retardates and the voluntary rendition of necessary services at the request of the retardate, parent or legal guardian, and have assumed that any retardate in a state institution is there involuntarily. See, *Halderman v. Pennhurst*, 446 F.Supp. 1295, 1319 (1977); *Wyatt v. Stickney*, 344 F.Supp. 387, 390, fn. 5 (1972).

That approach universally puts the onus of the retardates' condition upon the states and is a questionable application of state action principles. See, *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149 (1978).

Whatever its merits, the Court below turned the "right to treatment" theory on its head by holding that the DD Act, passed pursuant to Congress' power to implement the Fourteenth Amendment, obligates the states to treat all of its developmentally disabled residents and to do so in a manner that is least restrictive to personal liberties. That construction is inconsistent with the right to treatment theory, which only requires treatment as the quid pro quo for a deprivation of liberty. There is no authority to support the proposition that the Fourteenth Amendment affirmatively obligates the states to render services to its citizens whether or not the state desires to render such services or is fiscally able to provide such services. Wherefore, the Court's conclusion that Congress intended to implement the Fourteenth Amendment is clearly erroneous.

II. The Act, As Construed By The Court Below, Impermissibly Interferes With Traditional State Functions.

The Court below recognized that a Tenth Amendment issue would be presented if a private cause of action was implied from a grant program. 612 F.2d at 98, 99. The issue was avoided by its holding that the DD Act was passed pursuant to Congress' power to implement the Fourteenth Amendment. In light of the discussion, *supra*, showing that the Act clearly was not passed pursuant to the Fourteenth Amendment, it is necessary to consider whether the Act, as construed by the Third Circuit, violates the Tenth Amendment to the United States Constitution.

National League of Cities v. Usery, 426 U.S. 833, 851 (1976), held that the Tenth Amendment bars the federal government from impermissibly interfering with traditional governmental functions of the States.

A determination of the constitutionality of the federal action requires a balancing of the federal interests against the degree of federal intrusion upon state autonomy. *Develop-*

ments in the Law-Zoning, 91 HARV. L. REV. 1427, 1613 fn. 159 (1978); *National League of Cities, supra*, p. 856 (Blackman, J.) (concurring opinion); *Elrod v. Burns*, 427 U.S. 347, 375 (1976) (dissenting opinion).

National League of Cities voided the 1974 Amendments to the Fair Labor Standards Act, which extended federal wage and hour requirements to the states. Subsequent lower court decisions have held other activities to be within the protected sphere of state sovereignty. *United States v. Best*, 573 F.2d 1095, 1102 (9th Cir. 1978) (licensing of drivers is a traditional state function); *N.L.R.B. v. Highview, Inc.*, 590 F.2d 174, 178 (5th Cir. 1979) (the care of the aged, sick and the indigent is a traditional state function); *Jordon v. Mills*, 473 F.Supp. 12 (E.D. Mich 1979) (operation of prisons is a traditional state function).

Clearly, care of the retarded has traditionally been reserved to the states in their role as *parens patriae*. *Parham v. J. R.*, U.S. , 99 S.Ct. 2493 (1979); *Addington v. Texas*, U.S. , 99 S.Ct. 1804 (1979); *McIntosh v. Dill*, 86 Okl. 1 (1922); *Johnson v. State*, 18 N.J. 422 (1955).

Just as clearly, the Act, as construed by the Court below, extensively interferes with the states' function by dictating who is to receive services (all of the developmentally disabled) and the manner by which the services are to be rendered (in the least restrictive manner).

Finally, the federal interest is clearly insubstantial when balanced against the extensive interference with traditional state functions. Specifically, only a small proportion, approximately one percent, of all funds available for the care of the developmentally disabled are provided under the Act. House Rep. No. 94-58, *supra*, p. 6, *reprinted in* 2 [1975] U.S. Code Cong. § Ad. News 919, 924. Given the limited funding available under the Act, the purpose of the program is to promote ". . .

effective planning by the states of their programs, initiation of new needed programs, and filling the gaps among existing efforts." *id.*

Wherefore, the Act, as construed by the Cout below, impermissibly interferes with traditional state functions in violation of the Tenth Amendment to the United States Constitution.

III. The Court Below Erred In Holding That A Private Cause Of Action Could Be Implied From The Act.

The Court below applied the four factor analysis of *Cort v. Ash*, 422 U.S. 66 (1975), and concluded that a private right of action was implied in the Act.

That conclusion is inconsistent with the comprehensive administrative procedures established by the Act. See generally, 42 U.S.C. §6063 and 42 U.S.C. §6068.

That conclusion is also inconsistent with the fact that the Act concerns a subject matter that has been "traditionally relegated to state law". *Cort v. Ash, supra*, p. 78. This Court has repeatedly been reluctant to involve the federal courts in administering state institutions or in making medical or psychiatric judgments. See *Bell v. Wolfish*, U.S. , 99 S.Ct. 1861 (1979); *Rizzo v. Goode*, 423 U.S. 362, 378- 380 (1976); *Secretary of Public Welfare of Pennsylvania v. Institutional Juveniles*, U.S. , 99 S.Ct. 2523 (1979); *Parham v. J.R., supra*.

Wherefore, the Third Circuit erred in implying a private cause of action since Congress has provided alternative methods of enforcing whatever rights might be provided by the Act, without involving the federal courts in making difficult medical judgments in an area that has traditionally been reserved to the states.

IV. The Act Does Not Provide The Developmentally Disabled With A Right To Treatment.

The difficult constitutional issues, discussed *supra*, are presented due to the construction of the Act by the Court below, holding that the Act entitles every developmentally disabled person to treatment which must be provided in the least restrictive manner. While the Bill of Rights section, 42 U.S.C. §6010, is ambiguous, the construction by the Court below is inconsistent with the history of the Act, the legislative history of the 1975 Amendments and implementing HEW regulations.

Federal involvement in the area commenced with the Mental Retardation Facilities and Mental Health Centers Construction Act of 1963, P.L. 88-164, 77 Stat. 282 (1963), which provided grants to the states for construction of mental retardation facilities. House Rep. No. 94-58, 94th Cong., 1st Sess. 2, 4, *reprinted in* 2 [1975] U.S. Code Cong. and Ad. News 919, 920, 922. The Act was substantially amended and renamed by the Developmental Disabilities Services and Facilities Construction Amendments, P.L. 91- 517, 84 Stat. 1316 (1970), which broadened the scope of the Act from the retarded to the developmentally disabled generally and which authorized formula grants to the states for planning, administration and services in addition to the previously authorized grants for construction. House Rep. No. 94-58, *supra*, p. 4, *reprinted in* 2 [1975] U.S. Code Cong. and Ad. News 919, 922. The Act was subsequently amended and renamed the Developmentally Disabled Assistance and Bill of Rights Act, P.L. 94-103, 89 Stat. 486 (1975) and further refined by the Developmental Disabilities Act Amendments of 1978, P.L. 95-602.

The Act provides grants to states electing to participate in the program. 42 U.S.C. §6063. Only a small percentage, approximately one percent, of all funds available from federal,

state and local sources for services to the developmentally disabled are provided under the Act. House Rep. No. 94-58, *supra*, p. 6, *reprinted in* 2 [1975] U.S. Code Cong. and Ad. News 919, 924; House Rep. No. 95-1188, 95th Cong., 2nd Sess., p. 51, *reprinted in* 6 [1978] U.S. Code Cong. and Ad. News 7355, 7359.

A state seeking funds under the Act must have a plan approved by the Secretary of Health, Education and Welfare, 42 U.S.C. §6063(a), based upon compliance with the conditions outlined in 42 U.S.C. §6063(b). The conditions of compliance are general with the participating states given broad administrative discretion within priorities established by Congress. 42 U.S.C. §6063 (b)(4)(B) (1979 Supp.).

Given the limited funding available under the Act, the purpose of the program is to promote "... effective planning by the states of their programs, initiation of new needed programs, and filling of gaps among existing efforts."[1] House Rep. No. 94-58, *supra*, p. 6, *reprinted in* 2 [1978] U.S. Code Cong. and Ad. News 919, 924. Accordingly, those conditions of participation relating to the rendition of services apply only to programs receiving funds under the Act. For example, "services furnished . . . *under the plan*" and facilities in which they are provided must meet regulatory standards prescribed by HEW. 42 U.S.C. §6063(b)(5)(A)(i), and buildings "*used in conjunction with the delivery of services assisted under the plan*" must meet the requirements of the Architectural Barriers Act of 1968. 42 U.S.C. §6063(b)(5)(A)(ii).

The Developmentally Disabled Assistance and Bill of Rights Act of 1975 added, for the first time, the "Bill of Rights" section, 42 U.S.C. §6010. Even these provisions, however, are

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[1]The purpose of the Act changed somewhat with the 1978 Amendments, discussed *infra*.

obligatory upon the states only to the extent that funds under the Act are utilized to provide the services at issue.

> "(C) The plan must contain . . . assurances . . . that the *human rights* of all persons with developmental disabilities . . . who are receiving treatment, services or habilitation *under programs assisted under this chapter will be protected consistent with section 6010* of this title (relating to the rights of the developmentaly disabled)." 42 U.S.C. §6063(b)(5)(C). (Emphasis added)

The Committee report compels the conclusion that the states' obligations are limited to assistance under the Act.

> "The intention of the conference committee is that the habilitaton plan be required only when the Federal assistance under this Act contributes a portion of the cost of the habilitation services to the developmentally disabled person. If, for example, the only Federal assistance received by a program is used solely to purchase a bus to transport developmentally disabled persons, then a written habilitation plan would not be required. If, on the other hand, a program to provide habilitation services to developmentally disabled individuals is supported in whole or in part by Federal funds under this Act, a written habilitation plan would be required for each program participant." House Rep. 94-58, *supra*, p. 43, *reprinted in* 2 [1975] U.S. Code Cong. and Ad. News 919, 963.

In addition, the agency charged with enforcement of the Act (HEW) has issued regulations requiring only that the state plans ensure that those who receive services under the Act be provided with their human rights and treated in accordance with an individual habilitation plan. 45 C.F.R.

§1386.1(b)(5)(vi), 45 C.F.R. §1386.1(b)(5)(x). The implementing regulations of HEW are entitled to deference. *New York Department of Social Services v. Dublino*, 413 U.S. 405(1973).

Finally, the construction of the Court below is inconsistent with the repeated provisions, discussed *supra*, that limit the states' obligations to those assisted under the Act. See especially 42 U.S.C. §6063(b)(5)(C) and 45 C.F.R. §1386.1(b)(vi). It is a well established rule of law that a statutory course of action may only be found upon a breach of a statutory duty. The Act nowhere places a duty upon the states to treat the disabled except for those requirements on state plans which relate to the treatment of those assisted under the Act. Since the Act limits the states' obligations, it just as easily follows that any "right" provided by 42 U.S.C. §6010 is enforceable against the federal government in this "co-operative" program of providing services to the handicapped.[5]

V. The Act Does Not Obligate The States To Render Services In The Least Restrictive Manner.

As noted, *supra*, the Court below held that the developmentally disabled have a "right to treatment" which is to be provided in the "least restrictive" manner. The source of the "right" to be treated in the least restrictive manner is 42 U.S.C. §6010(2) which provides that:

> "The treatment, services, and habilitation for a person with developmental disabilities *should be* designed to maximize the developmental potential of

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[5]Curiously, the Court below never mentions the limitations of 42 U.S.C. §6063(b)(5) and 45 C.F.R. §1386.1(b)(vi). Indeed at 612 F.2d 96, the Court notes that, "(m)ore over, the revised statute contains a section requiring states to conform their plans to the dictates of the Bill of Rights provision, Section 6010," but fails to note that the requirement is limited to assistance furnished under the Act.

> the person and *should be* provided in the setting that is least restrictive of the person's personal liberty." (emphasis added)

The language of the statute uses the precatory language, "should be", in describing the desired treatment setting. Such language is inconsistent with the Court's finding of a mandatory duty to provide services in a prescribed manner.

The legislative history to the 1975 Amendments is in accord with the Conference Report again using the precatory language "should be" in describing the desired treatment setting. House Rep. 94-58, *supra*, p. 42, *reprinted in* 2 [1975] U.S. Code Cong. and Ad. News 919, 961.

The 1975 amendments did encourage deinstitutionalization by requiring that specified percentages of the States' allotments be spent on eliminating inappropriate placement in institutions. P.L. 94-103, *formerly codified at* 42 U.S.C. §6062(a)(4). Again the legislative history of the Act clearly indicates that the funding requirement was only intended to encourage a trend toward community based treatment.

> ". . . the Committee has chosen to include a specific requirement that state programs plan for as much deinstitutionalization as is feasible, and earmark monies for this purpose . . . It is anticipated that these requirements will prompt *some movement* of patients from State institutions back into their communities." House Rep. No. 94-58, *supra*, p. 10, *reprinted in* 2 [1975] U.S. Code Cong. and Ad. News 919, 928. (emphasis added)

Significantly, the requirement that the states earmark funds for deinstitutionalization was deleted by the 1978 amendments which now require that states devote sixty-five percent of the funds received under the Act to any one of four

specified priority areas of service, one of which is community based services. 42 U.S.C. §6063(b)(4)(A) (1979 Supp.), P.L. 95-602, 92 Stat. 3010. See generally House Rep. No. 95-1188, *supra*, p. 2, 10, *reprinted in* 6 [1978] U.S. Code Cong. and Ad. News 7355, 7356, 7364.

The Court below reached its conclusion by recognizing a Congressional *preference* for deinstitutionalization; that "until 1978" state plans were required to contain a plan for the elimination of inappropriate placements in institutions and to "support the establishment of community programs as alternatives". 612 F.2d at 104. The Court further cites the remarks of Congressmen Carter and Biaggi which indicate a preference for deinstitutionalalization. From these expressions of *preferences* for deinstitutionalization, the Third Circuit found a right to treatment in the least restrictive manner. 612 F.2d at 104, 105.

As pointed out by the dissenting opinion, an implied cause of action requires the breach of a statutory duty. The Court below elevated a preference for least restrictive treatment into a mandatory duty, without statutory authority to do so.

> "The duty of the states under the Act is to provide alternative individual habilitation to the extent feasible, which includes a wide variety of fiscal concerns. Yet the impact of the approach taken by the majority is exactly the opposite: it imposes a duty to provide less restrictive treatment, regardless of cost or available funds . . . It is improper to say an implied cause of action exists and then impose new substantive duties nowhere present in the statute in question." *Halderman v. Pennhurst*, 612 F.2d at 119 (dissenting opinion).

It should also be noted that the Third Circuit, in finding a preference for disinstitutionalization, relied in large part on

statutory provisions that had been repealed by the 1978 amendments, effective one and one-half years before its recent decision. As discussed *supra*, the states must now devote the majority of its effort under the Act in any one of four areas of priority, one of which is community services. 42 U.S.C. §6063(b)(4)(B)(i).

Furthermore, well established rules of construction have developed concerning co-operative federal grant programs wherein Courts have consistently refused to require states to provide all services that are authorized or appropriate, but, instead, have recognized the states' rights to tailor their plans according to fiscal requirements and local preferences as long as the state plans met those requirements mandated by federal law. *Beal v. Doe*, 432 U.S. 438 (1977); *Quern v. Mandley*, 436 U.S. 725 (1978); *Roe v. Norton*, 522 F.2d 928 (2nd Cir.), *on remand, 408 F.Supp. 660 (D.Conn. 1975) (3-judge Court), rev'd sub nom Maher v. Roe*, 432 U.S. 464 (1977).

Finally, the minimal federal finding belies federal intent to require that the states always provide treatment in the least restrictive alternative in this "co-operative" federal grant program. See, *Quern v. Madley*, *supra*, p. 745, 746.

CONCLUSION

The Petition for a Writ of Certiorari should be granted.

Respectfully submitted.

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OCTOBER TERM, 1979

NO. 79-1404

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,

Petitioners,

v.

TERRI LEE HALDERMAN, et al.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

AMICI CURIAE BRIEF OF NEW YORK, ILLINOIS, WASHINGTON, NEW HAMPSHIRE AND WEST VIRGINIA IN SUPPORT OF THE GRANT OF A WRIT OF CERTIORARI

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Opinions Below

The opinion of the United States Court of Appeals for the Third Circuit appears at 612 F. 2d 84.

The opinion and order of the United States District Court for the Eastern District of Pennsylvania both appear at 446 F. Supp. 1295.

Consent of the Parties

Consent of the parties is not required since this brief on behalf of the States of New York, Illinois, Washington, New Hampshire, and West Virginia as Amici Curia is sponsored by their respective Attorneys General. U.S. Sup. Ct. R. 42.

Interest of Amici Curiae

The State of New York through its Office of Mental Retardation and Developmental Disabilities (hereinafter "OMRDD") currently spends in excess of one half billion dollars annually in providing a wide spectrum of services to developmentally disabled individuals within New York State. A portion of those funds goes toward purposes such as research, prevention, and public education. The major allocation of New York's resources, however, is to the active, direct care and treatment of the developmentally disabled, both in the state's 19 developmental centers and its many hundreds of community living alternatives.*

The State of Illinois, Department of Mental Health and Developmental Disabilities (DMHDD) provides services to the second largest population of developmentally disabled (DD) individuals found in the United States. Illinois DD patient population at present includes 5,964 in State operated facilities (in-patient), 4,377 in State operated clinics (out-patient), and 26,916 in community based facilities. It has been estimated that 122,255 people within the State of Illinois suffer from some developmental disability. At the present time Illinois is involved in developing a comprehensive plan of deinstitutionalization in order to effectuate the requirements not only of the law, but also of good clinical practice. The deinstitutionalization plan (DI plan) entails years of planning for the eventual placement of DD individuals presently receiving care in state operated facilities into community based facilities more appropriate to their needs. Pursuant to the DI plan it is projected that the number of in-patient days for the average patient will drop from 45,043 in 1970 to 3,193 in 1982. Approximately one hundred eighty million dollars will be spent by Illinois in fiscal year 1980 to maintain its state operated facilities for the developmentally disabled. Sixty two million dollars

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* New York State's program is more fully described in Point IA *infra*.

will be spent in the same fiscal year in grants to community based facilities.

Washington State provides care and habilitation for developmentally disabled persons through a variety of residential and non-residential services. There are five (5) residential schools for the mentally retarded in the state serving approximately 2,100 persons with a planned population of 1,750 by July, 1982. Each of these five state schools received federal monies and is certified as an ICF/MR. These state scools are operated by the Department of Social and Health Services. The Department is presently operating under a system-wide five year program of compliance adopted pursuant to 45 CFR 249.12 and 249.13 which provides a detailed timetable for accomplishing the required staffing improvements and physical renovations necessary to meet regulations. The state plans were approved by DHEW Region 10, Seattle, Washington.

A major construction plan has been implemented to demolish outmoded buildings and replace them with smaller and newer facilities for residential care at these five central core facilities. In addition, Washington has increased funding for community services. In contrast to ten years ago when community programs only constituted 3 percent of the total Developmental Disabilities budget, the Legislature in 1979 increased this to 27 percent of the total budget of $158,022,600. This does not include funds for a) special education funds for local school districts; b) Vocational Rehabilitation funds for DD clients; c) Community ICF/MR facilities—Title XIX Medicaid; d) Social Security and other client benefits expended for services; and e) county funds.

Each of the States joining in this amici brief, is defending at this time, at least one major litigation, brought as a class action, raising many of the issues decided by the Courts below in this action, relating to the method of and extent to which they provide care and treatment for the mentally retarded. Those cases include: *Society for Goodwill to Retarded Children, Inc.* v. *Carey,* 78-C-1847

(E.D.N.Y.); *Illinois Association for Retarded Citizens et al.* v. *Governor James Thompson et al.*, 80-C-0914 (N.D. Ill., E. Div.); *Washington Association for Retarded Citizens, et al.* v. *Thomas*, C-79-1235V (W.D. Wash.) *Garrity et al.* v. *Gallen, et al.*, 78 C. 116 (D.N.H.) and *Medley Macel et al.* v. *Leon Ginsberg, Commissioner of West Virginia, Department of Welfare, et al.*, 78 Civ. 2099 CH (W. Va., S.D.)

New York State and those states joining with it in this petition have a very real and substantial interest in obtaining the clearest and earliest possible guidance from this Court. Short and long-term planning of services can be effective only if state policymakers and administrators know that their planned services and time frames do not conflict with federal requirements as directed by individual district courts. State officials must be advised as soon as possible whether receipt of funding under 42 U.S.C. § 6000 et seq., the Developmentally Disabled Assistance and Bill of Rights Act (hereinafter the Act) obligate them to restructure their complex service systems and if so, to what extent and pursuant to what guidelines, so that their multimillion dollar programs of aid to the developmentally disabled can comport with the requirements of applicable federal statutes and constitutional provisions.

Statement of the Case

This is a class action lawsuit, brought on behalf of all current and future residents of the Pennhurst State School and Hospital, alleging that the facility is operated in a manner that violates its mentally retarded residents' constitutional and statutory rights.*

After an extensive trial, the District Court (*Broderick*, J.) found that the facility violated its residents' constitu-

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* The parties below did not contest the claim that Pennhurst was, under any test, an inadequate facility, nor by presenting this brief, are amici states condoning in any way the conditions which existed at Pennhurst.

tional right to "habilitation", *Halderman* v. *Pennhurst State School and Hospital,* 446 F. Supp. 1295, 1314, 1321 (E.D. Pa. 1977), as well as their statutory right to "non-discriminatory habilitation" under Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, *id.* at 1323. Rather than ordering that the facility be improved, the District Court ordered that the facility be closed and appointed a master to supervise the transfer of residents into the community, *id.* at 1325.

On appeal, the Third Circuit Court of Appeals largely affirmed the relief ordered below, but relied on an entirely different legal approach than had the District Court, *Halderman* v. *Pennhurst State School and Hospital,* 612 F. 2d 84 (3d Cir. 1979), basing its decision on federal and state statutory grounds, without reaching the constitutional issues decided by the District Court. The majority ruled that Congress was legislating to implement the Fourteenth Amendment when it passed the Act, *id.* at 98, and that the Act provided the developmentally disabled with a private right of action and a right to habilitation, *id.* at 95, which must be provided in the setting that is least restrictive to personal liberty, *id.* at 107. The Third Circuit further held that there was a presumption in favor of community-based care, but modified the lower court order so as to permit the continued operation of Pennhurst for those for whom the presumption could be rebutted.

REASONS FOR GRANTING THE WRIT

1. The Decision of the Court Below Raises Significant Questions With Regard To The Construction Of Federal Statutes Intended To Aid The Mentally Retarded Which Are Of Great Public Interest To Each State Receiving Federal Funds And Administering A Program For the Mentally Retarded

The decision of the Court below, as framed, mandates that any state receiving funds under the Act pursue a method of habilitation for the mentally retarded which

favors community placement and which guarantees a right to habilitation in the least restrictive environment, both under the supervision of a court appointed master if necessary. In basing its holdings in large part* on federal statutes passed to implement the Fourteenth Amendment, which apply equally to the amici states, the decision of the Court below necessarily affected the administration of each program for the mentally retarded operated by an amicus state.

A. New York is presently making tremendous financial investments in its program of care and habilitation for the mentally retarded which could be declared misguided upon ultimate judicial resolution of these significant legal questions.

A recent estimate based on the disability prevalence rate, is that there are approximately 376,659 developmentally disabled persons in New York State. At the end of the fiscal year 1979-80 there were just under 14,000 developmentally disabled persons residing in the 19 inpatient residential facilities operated by the State Office of Mental Retardation and Developmental Disabilities. These facilities vary in size from about 120 residents to over 2000 residents.

The Department is presently operating under a systemwide five year program of compliance adopted pursuant to former 45 CFR 249.12 and 249.13 (new 42 CFR 112 *et seq.*) which contains a detailed timetable for accomplishing the required staffing improvements and physical renovations necessary to meet federal regulations. The plans of correction were approved by DHEW Region II, Office of Long Term Care and Standards Enforcement.

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* The Third Circuit based part of its holding on Pennsylvania Statutes which would have no bearing on the amici states. The District Court had based its holding on a federal constitutional right to habilitation in community facilities—a holding which would impact *all* the states.

Pursuant to the plan, the number of institutionalized clients will be 11,459 by the end of fiscal year 1980-1981, and 9,919, the certified occupancy rate, by the end of fiscal year 1981-82.

In addition to developmentally disabled clients living in developmental centers, OMRDD has established, with the necessary assistance of voluntary agencies and other third-parties providers, a broad range of alternative living arrangements. Those alternative living arrangements consist of community ICF/MR's, skilled nursing facilities, and community residences which are subdivided into apartments, community residences, and family living situation. In addition, New York provides or funds a wide range of day program alternatives, including day training, day treatment and sheltered workshop programs.

In order to carry out the goals stated in the OMRDD-Five Year Comprehensive Plan and the 1980 Update, the Legislature has appropriated for OMRDD purposes approximately $700,000,000 for fiscal year 1980-81. Almost $500,000,000 of this is allocated for state purposes, the bulk of which is directed toward prevention and the care of the mentally retarded and developmentally disabled. Some other items receiving substantial state purposes funds are quality assurance, the family care-personal care program and research in mental retardation.

Another major portion of the OMRDD budget is for local assistance, totalling approximately $100,000,000. These funds are provided to carry out the purpose in Article 41 of New York's Mental Hygiene Law, to assist local governments in the care and habilitation of the developmentally disabled.

In addition, there is a $29,000,000 capital construction appropriation, which serves two purposes. The first is state aid to municipalities and other public and not-for-profit private agencies for acquisition of property, construction and rehabilitation of community mental retarda-

tion facilities, pursuant to Article 41 of New York's Mental Hygiene Law. Second, capital construction funds are appropriated for the alteration and improvements of state-operated facilities to achieve compliance with federal standards relating to intermediate care facilities for the mentally retarded and the Consent Judgment reached by the parties to the *Willowbrook* case, *New York State Association for Retarded Children, Inc., et al.* v. *Carey*, 72 C. 356/357 (E.D.N.Y.). The balance of approximately $57 million dollars goes largely to residential and non-residential services, support programs and specialized programs denominated "prevention and care maintenance undistributed." The structure of the budget emphasizes the high degree of reliance on and cooperation with local governments and third-party providers needed to implement the State's plans for deinstitutionalization.

Despite the large amount of money being spent by New York for the mentally retarded, resources are limited. There is a delicate balance drawn by the Legislature and Executive allocating these resources for distribution over the vast array of services provided and responsibilities assumed by the State, both for the mentally retarded and for all other undertakings of the State. Moreover, in spite of the enormous investment by New York State in appropriate programs and living arrangements for the developmentally disabled, and the very substantial gains made by New York State in deinstitutionalizing its developmentally disabled clients, an even vastly greater undertaking by New York would be required to comply with the Third Circuit's decision below.

Clearly, the scale and scope of New York's programs for the mentally retarded make it extremely important to New York to receive from the highest possible authority, at the earliest possible opportunity, a clear understanding as to whether the State is directing its efforts and funds in a statutorily and/or constitutionally appropriate fashion. Should the mandate of the Supreme Court warrant re-

structuring of New York's system, such a ruling would permit development at the earliest opportunity of a proper long term program with any changes in emphasis or financial allocations which may be necessary. Furthermore, timely Supreme Court resolution can allow this restructuring, if mandated, to occur through efficient system-wide administrative and legislative direction, without necessitating the intervention of federal courts and federal masters.

B. Litigation similar to Pennhurst, pending in the *amici* states, would benefit from an early ruling on issues that have already produced a conflict among the circuits.

At present, there are inconsistent and varying adjudications with respect to the constitutionally and/or statutorily mandated requirements which a state must meet in providing services to the mentally retarded. See, e.g. *Kentucky Association for Retarded Citizens* v. *Conn,* W.D. Kentucky, C 78-0157 LA Memorandum Decision dated 3/21/80; *Wyatt* v. *Stickney,* 344 F. Supp. 387 (W.D. Ala., 1972) aff'd in part, remanded in part, reversed in part, *Wyatt* v. *Aderholt,* 503 F. 2d 1305 (5th Cir. 1974). This ambiguity in applicable legal principles serves to foster costly, complex class-action litigation, as well as to introduce substantial uncertainties into the process of long-term planning for the deliver of services to the mentally retarded and developmentally disabled.

New York is presently defending itself in a major, complex litigation brought on behalf of a purported class, which presents claims for relief very similar to those sought by plaintiffs in the *Pennhurst* litigation, including the placement of all of a developmental center's residents into community facilities. Plaintiffs in that suit, *Society for Good Will to Retarded Children, Inc.* v. *Carey, et al.,* 78 C. 1847 (E.D.N.Y.) allege that

> "Defendants have failed to provide plaintiff and others similarly situated with constitutionally and statutorily

> mandated levels of care, habilitation, training, education and treatment in a manner or place designed or capable of maximizing the developmental potential of each individual and same are not provided in a setting which is the least restrictive of each individual's personal liberty, all of which can only be provided in community residences and not in residential institutions such as SUFFOLK DEVELOPMENTAL CENTER."

The problems presented by this lawsuit, where applicable legal principles are uncertain, include the following:

1) Neither the parties nor the Court can tailor the case to established legal principles, thus greatly increasing the cost, complexity and duration of the trial.

2) Since the relief, if any, will be limited to residents of a particular facility, deficiencies would not be addressed on a system-wide basis, possibly resulting in inconsistent standards within the same state, and the drawing of resources from one group to another, in order to comply with orders favoring the plaintiffs.

A definitive statement from this Court as to the requirements, if any, imposed upon New York, which receives limited funds under the Act, would serve to refine the issues presented to the District Court for ruling, thereby reducing the costs, complexity and duration of a trial and allowing for more resources to be devoted to patient care and planning.

The pendency of *Society for Good Will* and the knowledge that appellate review in that action is at least one year away, makes most desirable the early review by this Court of a case raising similar statutory and constitutional claims, and which is the only case ready for review. The uncertainty within the State as to whether it will be able to proceed with its ICF/MR plan, and other long-term ob-

jectives, as presently intended, or whether there will be a radical restructuring of services based upon a district court interpretation of the Act, the Rehabilitation Act of 1973, Section 504, 29 U.S.C. § 794 or the Constitution, could be alleviated by timely Supreme Court settling of responsibilities. Of equal importance, this resolution would permit a system-wide response, as opposed to a facility-specific response that results from one facility's being subject to a right-to-habilitation suit.

CONCLUSION

The petition for a writ of certiorari should be granted.

Dated: New York, New York
May 8, 1980

Respectfully submitted,

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Supreme Court U. S.
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Nos. 79-1404, 79-1408, 79-1415, and 79-1489

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
v. *Petitioners,*

TERRI LEE HALDERMAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF FOR PETITIONERS

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QUESTIONS PRESENTED

1. Does the Developmentally Disabled Assistance and Bill of Rights Act require the States to develop, at their own expense, programs and facilities to provide "appropriate treatment" and "the least restrictive environment" for each developmentally disabled person?

2. If the Act imposes such requirements, does 42 U.S.C. § 1983 authorize their enforcement through private actions or does the Act commit their exclusive enforcement to the Secretary of Health and Human Services?

3. If the Act imposes such requirements and § 1983 authorizes their private enforcement, should relief have been limited to a declaration of those requirements and an injunction against federal funding or was the district court authorized to appoint a master to determine the appropriate community placement for each current and potential institutional resident and to require the State to fund these placements?

4. Does Pennsylvania law create a state-funded right to treatment for the mentally retarded, and, if so, can the relief ordered by the Court of Appeals be predicated on such a right?

TABLE OF PARTIES

PETITIONERS

Commonwealth Petitioners (No. 79-1404):

Pennhurst State School & Hospital, Department of Public Welfare of the Commonwealth of Pennsylvania;

Frank S. Beal, Secretary of the Department of Public Welfare;

Stanley Meyers, Deputy Secretary for Mental Retardation, Department of Public Welfare;

Helene Wohlgemuth, Former Secretary, Department of Public Welfare;

Aldo Colautti, Executive Deputy Secretary, Department of Public Welfare;

Wilbur Hobbs, Deputy Secretary for Southeastern Region, Department of Public Welfare;

Russell Rice, Jr., Commissioner of Mental Retardation for Southeastern Region, Department of Public Welfare;

C. Duane Youngberg, Superintendent, Pennhurst State School & Hospital;

Robert Smilovitz, Former Assistant Superintendent, Pennhurst State School & Hospital;

Joseph Foster, Assistant Superintendent, Pennhurst State School & Hospital;

Margaret Green, Betty Uphold, Alice Barton, P.E. Klick, Dr. Parocca, Helen Francis, employees and agents of Pennhurst State School & Hospital;

John Doctor, James Nurse, Jane Aide, Jill Therapist, Richard Roe, Jane Doe, unknown and unnamed staff, employees and agents of Pennhurst State School & Hospital.

County and Philadelphia Petitioners (Nos. 79-1408, 79-1415):

George Metzger, Joseph Catania, and Roger Bowers, Commissioners for Bucks County;

Robert Strebl, Earl Baker and Leo McDermott, Commissioners for Chester County;

Faith R. Whittlesey, Charles Keeler, and William Springler, Commissioners for Delaware County;

A. Russell Parkhouse, Frank W. Jenkins, and Lawrence H. Curry, Commissioners for Montgomery County;

Mayor Frank L. Rizzo and the City Council of Philadelphia, as Authorities for Philadelphia County;

Peter Bodenheimber, Mental Health/Mental Retardation Administrator for Bucks County;

William A. McKendry, Mental Health/Mental Retardation Administrator for Chester County;

P. Paul Burrichter, Mental Health/Mental Retardation Administrator for Delaware County;

Hermann A. Roether, Mental Health/Mental Retardation Administrator for Montgomery County;

Leon Soffer, Mental Health/Mental Retardation Administrator for Philadelphia County, Commonwealth of Pennsylvania.

Parents-Staff Petitioner (No. 79-1489):

Pennhurst Parents-Staff Association.

* * * *

RESPONDENTS

Halderman Respondents:

Terri Lee Halderman, a retarded citizen, by her mother and guardian, Winifred Halderman;

Larry Taylor, a retarded citizen, by his parents and guardians, Elmer and Doris Taylor;

Kenny Taylor, a minor, a retarded citizen, by his parents and guardians, Elmer and Doris Taylor;

Robert Sobetsky, a minor, a retarded citizen, by his parents and guardians, Frank and Angela Sobetsky;

Theresa Sobetsky, a retarded citizen, by her parents and guardians, Frank and Angela Sobetsky;

Nancy Beth Bowman, a retarded citizen, by her parents and guardians, Mr. and Ms. Horace Bowman;

Linda Taub, a retarded citizen, by her parents and guardians, Mr. and Mrs. Allen Taub;

George Sorotos, a minor, a retarded citizen, by his foster parents, William and Marion Caranfa;

The Parents and Family Association of Pennhurst.

PARC Respondents and Cross-Petitioners (No. 79-1414):

Pennsylvania Association for Retarded Citizens;

Jo Suzanne Moskowitz, a minor, by her parents and next friends, Leonard and Nancy Moskowitz;

Robert Hight, a minor, by his parents and next friends, John and Jeanne Hight;

David Preusch, a minor, by his parents and next friends, Calvin and Elizabeth Preusch;

Charles DiNolfi.

The United States of America

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

Nos. 79-1404, 79-1408, 79-1415 and 79-1489

PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
Petitioners,

v.

TERRI LEE HALDERMAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR PETITIONERS

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Third Circuit, 89a-162a [1], is reported at 612 F.2d 84. The opinion of the United States District Court for the Eastern District of Pennsylvania, 6a-75a, issued on December 23, 1977, and its order issued on March 17, 1978, 79a-88a. Both appear at 446 F. Supp. 1295.

JURISDICTION

The judgment of the Court of Appeals was entered on December 13, 1979. Commonwealth, County, and Philadelphia petitioners filed their petitions for certiorari in Nos. 79-1404, 79-1408, and 79-1415, on or before March 12, 1980. Mr. Justice Brennan extended the time for filing the petition of Pennhurst Parents-Staff Association until April 11, 1980; the Association filed its petition in No. 79-1489 on March 20, 1980. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1).

[1] Appendix references, cited as "—a," are to the Joint Appendix submitted with the Petitions for Writs of Certiorari filed in Nos. 79-1404, 79-1408 and 79-1415. Petitioners have filed a Motion to Dispense with the Requirement of a Joint Appendix, which is still pending before this Court.

STATUTORY PROVISIONS INVOLVED

This case involves the provisions of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§ 6000 *et seq.* (1975 & 1978 amend.), set forth in its entirety in the Appendix included in Petitioner Pennhurst Parents-Staff Association's Petition for a Writ of Certiorari, No. 79-1489. The case also involves the provisions of the Pennsylvania Mental Health and Mental Retardation Act of 1966, Pa. Stat. Ann. tit. 50, §§ 4101 *et seq.* (Purdon), set forth in relevant part at 225a-29a.

STATEMENT OF THE CASE

This case arose in May 1974, when a resident at Pennhurst Center for the Mentally Retarded ("Pennhurst") brought suit against various Pennsylvania officials in the United States District Court for the Eastern District of Pennsylvania (Broderick, J.), protesting conditions at the facility.[2] Plaintiff alleged that she was receiving substandard care at Pennhurst, and therefore, that Pennsylvania had violated her First, Eighth, Ninth and Fourteenth Amendment rights, as well as state law.[3] Plaintiff sued on her own behalf and on behalf of all

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[2] Pennhurst is located approximately 30 miles outside of Philadelphia on a large campus. Its living quarters range from small modern units to large older dormitory settings. At the time of trial, approximately 1230 mentally retarded persons resided there, almost three-quarters of whom were severely or profoundly retarded (*i.e.*, with IQ's below 35). 20a; 446 F. Supp. 1295, 1302. The district court recognized that Pennsylvania's reliance on Pennhurst had declined dramatically from the early 1960's when it housed nearly 4000 people. 19a; 446 F. Supp. 1302. Since then, Pennsylvania has relocated many of its residents in community placements. Nevertheless, institutional care remains an integral part of Pennsylvania's diversified program for the mentally retarded.

[3] Mental Health and Mental Retardation Act of 1966, Pa. Stat. Ann. tit. 50, §§ 4101 *et seq.* (Purdon) (set forth in relevant part at 225-29a).

others similarly situated,[4] seeking both monetary and injunctive relief.

Subsequently, the district court allowed the United States and the Pennsylvania Association for Retarded Citizens (PARC), along with six additional residents of Pennhurst, to intervene as plaintiffs. Seeking only injunctive relief, PARC added as defendants various officials and mental health administrators from each of the five counties surrounding Pennhurst. And, in contrast to the original plaintiff, who only sought an order improving conditions at Pennhurst, PARC contended that the State and county officials should be ordered to close the facility entirely and create community-based treatment facilities, called "community living arrangements" (CLAs), for its residents.[5] It based this claim not only on the constitutional provisions advanced by the original plaintiff, but also upon two federal statutes, § 504 of the Rehabilitation Act of 1973,[6] and the Developmentally Disabled Assistance and Bill of Rights Act (hereafter referred to as the "DD Act").[7] Subsequently, the original plaintiff filed amended complaints joining additional plaintiffs and adopting the theories of the intervenors, so that

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[4] The district court certified a class of "[a]ll persons who as of May 30, 1974, and at any time subsequent, have been or may become residents of Pennhurst . . . [including] persons resident at Pennhurst . . . , persons residing in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties who are on the waiting list for placement at Pennhurst . . . and persons residing in Bucks, Chester, Delaware, Montgomery and Philadelphia Counties, who, because of the unavailability of alternative services in the community may be placed at Pennhurst. . . ." 14a; 446 F. Supp. at 1300.

[5] Although the facility is owned and operated entirely by the state, the complaint in intervention alleged that county participation would be required in any plan to close Pennhurst.

[6] 29 U.S.C. § 794 (set out at 197a).

[7] 42 U.S.C. §§ 6000 *et seq.* (set forth in its entirety in the Appendix included in Petitioner Pennhurst Parents-Staff Association's Petition for a Writ of Certiorari, No. 79-1489).

all plaintiffs and intervenors argued that large treatment facilities such as Pennhurst were by their very nature unconstitutional and otherwise illegal.[8]

After trial, the district court rejected plaintiffs' damages claim, but nonetheless concluded that they had suffered deprivations of their constitutional and statutory rights, entitling them to injunctive relief. On Eighth Amendment, Equal Protection and Due Process grounds, the court found that "an institution such as Pennhurst" was an unconstitutional mode of providing residential services to the mentally retarded. 57a-58a, 68a; 446 F.Supp. at 1317-18, 1322.[9] The trial judge also concluded that the Rehabilitation Act of 1973 "in effect codified the constitutional right to equal protection," and that "consistency" thus required him to find "that Pennhurst residents' federal statutory right to habilitation in a non-discriminatory manner ha[d] been violated" as well. 71a-72a; *id.* at 1323. In addition, the court ruled that Pennsylvania law provided plaintiffs a "right to minimally adequate habilitation." 69a; *id.* at 1322. The district court did not rule on whether the DD Act had been violated. *See* 131a n.28; 612 F.2d at 104 n.28.

Thereafter, the trial court entered an order requiring that Pennhurst be closed and that its residents, and those on its waiting list, be relocated into CLAs to be created and funded by defendants. 79a-80a; 446 F.Supp. at 1326-28. To implement this order, the court appointed a special master pursuant to Fed. R. Civ. P. 53, who was authorized to prepare and eventually effect a plan for placing the twelve hundred and thirty residents then at Pennhurst, as well as others covered by the class, into CLAs. 84a-87a; 446 F.Supp. at 1326-28. The court also entered certain

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[8] The United States rested its claim only on constitutional grounds.

[9] According to the court, Pennhurst violated its residents' constitutional rights to "minimally adequate habilitation," to "non-discriminatory habilitation" and to be "free from harm." 57a-67a; 446 F.Supp. at 1317-21.

specific injunctions relating to the operation of Pennhurst until such time as the facility was closed, and empowering the Master to supervise that "interim" operation. 85a-88a; *id.* at 1328-29.

Appeals were taken by all defendants, challenging the district court's ruling on all counts as well as the breadth of the order and its manner of implementation.[10] Argument before a panel of the United States Court of Appeals for the Third Circuit was heard on January 9, 1979. When that panel was unable to reach a majority decision, the case was reheard *en banc* on September 6, 1979. 98a-99a; 612 F.2d at 90.

A sharply divided court (per Gibbons, J.) essentially affirmed the order below, relying, however, on an entirely different legal theory. Declining to rule on the constitutional and statutory bases invoked by the district court,[11] the Court of Appeals rested its decision instead on the DD Act.[12] First, the majority concluded that Con-

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[10] The Pennhurst Parents-Staff Association, petitioner in No. 79-1489 in this Court, had sought and was denied leave to intervene in the district court. It appealed this ruling to the Court of Appeals, which upheld the district court's denial. Order of Dec. 13, 1979, No. 78-1999. Its subsequent motion to intervene in proceedings before the Court of Appeals for purposes of filing a petition for certiorari in this Court was granted on March 4, 1980.

[11] The Court of Appeals did uphold the district court's interpretation of state law, ruling that it provided a right to treatment. This aspect of the decision, however, did not form the basis for the relief granted. The court made clear that state law required only that "to the extent Pennsylvania maintains facilities for the mentally handicapped, those facilities must provide adequate treatment or habilitation." 127a; 612 F.2d at 102. Thus, the court found that only federal law required the development of CLAs.

[12] No party briefed the DD Act claim before the district court. Nor was it raised by the parties in the Court of Appeals. Rather, it was first raised by the Court of Appeals itself, which requested supplemental briefs on the issue for purposes of the rehearing *en banc*. Significantly, at that time the United States did not argue

gress had provided "the mentally retarded with a right to treatment" that must be funded by the States. 109a; 612 F.2d at 95. Next, the court determined that the Act could be enforced through private actions such as the original plaintiff's in this case. 121a-122a; *id.* at 100. And, finally, the court held that the Act required that the treatment be provided only in "the least restrictive environment." 140a; *id.* at 107.

The Court of Appeals vacated the district court's order insofar as it required closure of Pennhurst,[13] holding that, while institutions were disfavored under the DD Act, they were not prohibited. Accordingly, on remand, the district court was instructed to make "individual determinations . . . as to the appropriateness of an improved Pennhurst for each such patient." 156a; *id.* at 114. In making these determinations, however, the court was to accord a "presumption" in favor of placing people in CLAs, 159a; *id.* at 115, and the Court of Appeals made clear that, in its view, few people should remain at Pennhurst. 139a; 612 F.2d at 107.[14]

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that the district court's judgment could rest on the DD Act. It claimed only that the ruling was "in accord with the objective" of the Act. Supplemental Brief of the United States (below) at 10.

[13] The Court of Appeals also vacated that portion of the district court's order requiring that alternative employment be provided to all employees of Pennhurst. 153a; 612 F.2d at 113.

[14] On remand, the district court established detailed procedures for implementing this decree. Initially, under the supervision of the Special Master's Office, a group consisting of the Pennhurst resident, his or her parent or guardian, an advocate or next friend for the resident, and the resident's case manager are to prepare a treatment plan for the resident. The County Administrator must then, subject to the Master's approval of the plan, locate and prepare a CLA for each individual resident. At that time, if there is no dispute, the resident is moved. If there is a dispute, a second master, called a "Hearing Master," is empowered to conduct a formal hearing to decide whether continued placement at Pennhurst would be more beneficial than placement in the newly-created CLA. If not, the new placement is to go forward, subject to possible review by the district court.

[Footnote continued]

Chief Judge Seitz, joined by Judges Aldisert and Hunter, dissented. Although assuming the existence of a right to improved conditions at Pennhurst, the dissenters disputed the majority's finding of "a general right to individualized treatment in the least restrictive environment." 164a; *id.* at 117. In so doing, the dissent considered and rejected each statutory and constitutional ground asserted by plaintiffs as supporting such a right.

The state, county and Philadelphia defendants, along with the intervening Parents-Staff Association, filed petitions for certiorari. In addition, PARC filed a conditional cross-petition, contending that the Court of Appeals erred in vacating that portion of the district court's order closing Pennhurst. All petitions were granted on June 9, 1980.[15] Thereafter, on June 30, 1980, a partial stay was granted by this Court, prohibiting court-ordered "movement of residents of the Pennhurst facility to 'appropriate community living arrangements.'"

SUMMARY OF ARGUMENT

I. The DD Act does not compel the States either to fund treatment or to provide the least restrictive environment.

A. Section 6010 of the Act, designated "The Bill of Rights," must be read in conjunction with the remainder of the statute, as well as with its legislative history and governing regulations. When so read, it is clear that § 6010 is nothing more than a statement of federal policy, to be encouraged through federal funding under the Act. *See Southeastern Community College* v. *Davis*, 442 U.S. 397 (1979). It is not a catalogue of new mandatory

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[14] [Continued]

The comprehensiveness of this remedial mechanism is reflected in the fact that from July 1978 through the end of July 1980, Pennsylvania has been ordered to pay more than $1.6 million for operation of the Master's Office and more than $30,000 for the Hearing Master.

[15] The Court declined to consider two questions presented by the petitions: (1) whether the class was properly certified; and (2) whether the United States had standing to intervene as a plaintiff.

federal standards that must be satisfied through massive financial outlays by the States.

B. Even if the Bill of Rights is read to impose certain requirements on the States, the extent of those requirements must be defined by the explicit provisions of the Bill itself, contained in § 6010(3). *See Kentucky Association for Retarded Citizens* v. *Conn*, No. C-78-0157LA (W.D. Ky. March 21, 1980).[16] That section does not compel the creation of widespread new facilities to assure treatment in the least restrictive environment. It simply prohibits the use of federal funds in any state facility that does not either provide appropriate treatment or satisfy certain basic criteria concerning food, shelter, and medical care. Thus, § 6010 at most establishes basic criteria to reinforce existing state and federal standards, not an overhaul of state programs of care for every developmentally disabled person.

II. Whatever obligations the DD Act imposes on States, it commits exclusive enforcement of those obligations to the Secretary of Health and Human Services. Although this Court recently ruled in *Maine* v. *Thiboutot*, 48 U.S.L.W. 4859 (June 25, 1980), that 42 U.S.C. § 1983 creates a private right of action to enforce rights secured by federal law, it has also recognized an exception to this remedy where Congress provides an exclusive means of enforcement. *See, e.g., Preiser* v. *Rodriguez*, 411 U.S. 475 (1973). Under the DD Act, Congress committed enforcement of all state-imposed obligations to the Secretary of Health and Human Services. Thus, Congress specifically charged the Secretary with assuring state compliance with the provisions of § 6010, *see* 42 U.S.C. § 6063(b)(5)(C), and it provided both procedures and sanctions to effectuate such compliance. Indeed, Congress specifically made allowance for private parties to participate in this carefully crafted process. To go beyond

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[16] This opinion, as yet unreported, is reprinted as an Appendix to Petitioners' Reply Memorandum on the Petitions for a Writ of Certiorari in this Court, and will be cited as "R.M. —a."

that method of enforcement, and to create a private judicial remedy as well, would both undermine a coherent enforcement approach, and open the federal courts to countless damage and injunctive actions contesting the appropriateness and restrictiveness of individual treatment programs.

III. Even if the Act imposes obligations as found by the Court of Appeals and authorizes their private enforcement, the relief ordered should have been limited to a declaration of those obligations and an injunction against federal funding under the Act. *See Rosado* v. *Wyman*, 397 U.S. 397 (1970). Congress made clear that its concern was to protect federal monies, *see* 42 U.S.C. §§ 6010 (3), 6062(a)(1)(C), and it specifically eschewed any intent to authorize a judicial takeover of the operation of state programs or facilities, *see* § 6003. By displacing traditional state administrative authority for providing care for the mentally retarded, the relief below contravenes well-settled principles of federalism as well. *See Rizzo* v. *Goode*, 423 U.S. 362 (1976).

IV. Under Pennsylvania law, services to the retarded are to be provided equitably to the extent funds are appropriated by the legislature. Pa. Stat. Ann. tit. 50, §§ 4301(d), 4509(5). The Court of Appeals recognized this funding limitation, and did not rely on state law to establish a right to treatment in the least restrictive environment. Accordingly, state law did not support its judgment. Moreover, institutional care is an integral part of Pennsylvania's statutory scheme of services for the retarded. Thus, in deciding this issue unnecessarily, and without the benefit of meaningful state court precedent, the Court of Appeals clearly misinterpreted state law.

ARGUMENT

At issue in this case is the proper application of the DD Act. The Court of Appeals, seizing on a subset of Congressional "findings" and dislodging them from their statutory context, held that the Act imposes two distinct duties on participating states: a duty to provide treatment and a duty to place each individual covered by the Act in a facility that is least restrictive of his liberty. If followed, this ruling would mean that every State must provide "appropriate treatment, services and habilitation" in the "least restrictive environment" for each of the "more than two million [developmentally disabled] persons" covered by the Act. §§ 6010(1), (2); 6000 (a)(1).[17]

Moreover, since the court below held that enforcement of these duties is lodged in the federal courts, the decision would open those courts to innumerable lawsuits by developmentally disabled persons seeking to dispute the nature or setting of their treatment. Concomitantly, as this case vividly demonstrates, the federal courts would necessarily displace state and local governments as the decisionmakers empowered to determine the proper allocation of resources and the appropriate treatment for each developmentally disabled person. The States would be left only to fund and implement the treatment prescribed by the federal court. There can be little doubt that this construction of the DD Act "would have amazed the legislators who voted for it." *Runyon* v. *McCrary*, 427 U.S. 160, 189 (1976) (Stevens, J., concurring).

Properly read, the DD Act is a funding statute, seeking to encourage state efforts to improve care for the developmentally disabled, but imposing neither of the

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[17] While this case involves only the mentally retarded, the statute in general, and the sections relied on by the Court of Appeals in particular, apply to all developmentally disabled persons. *See* 42 U.S.C. § 6001(7); 45 C.F.R. § 1385.2(a)(6).

intractable duties found by the Court of Appeals.[18] Moreover, to the extent that the Act may be read to impose such duties, it commits their enforcement exclusively to the Secretary of Health and Human Services (HHS). Finally, even if the Act is construed to create these duties and to authorize their private enforcement, relief should have been limited to a declaration of the duties and an injunction against the payment of federal monies unless the State complies with its obligations.[19]

I. THE DD ACT IMPOSES NO DUTIES ON THE STATES TO FUND "APPROPRIATE TREATMENT" OR "THE LEAST RESTRICTIVE ENVIRONMENT" FOR DEVELOPMENTALLY DISABLED PERSONS.

The Court of Appeals ruled that the DD Act created new federal obligations on the States to provide, at their own expense, appropriate treatment and to provide it in the least restrictive environment.[20] The court derived

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[18] We stress at the outset that all Petitioners agree that a State must run its institutions for the retarded in a decent and humane fashion. While we do not necessarily agree on the source[s] or contours of such a duty, we do agree that the DD Act does not impose it. Accordingly, the scope of that duty is not presented by this case. We note, in any event, that the remedy below, by authorizing the judicial takeover of Pennhurst and mandating deinstitutionalization, goes far beyond the scope of any such duty.

[19] We will further show that the Court of Appeals' interpretation of state law was also erroneous and that, in any event, even under the court's interpretation, state law does not authorize the relief imposed.

[20] Relying on the district court's opinion, the Court of Appeals defined the right to treatment (referred to interchangeably with the right to "habilitation") as "that education, training and care required by retarded individuals to reach their maximum development." 109a n.14; 612 F.2d at 95 n.14. While the court did not define the right to the least restrictive environment, it held that the right required the provision of care in CLAs except in "those individual cases, probably comparatively rare, [where] adequate habilitation could not be accomplished in any setting less restrictive than an institution. . . ." 139a; *id.* at 107.

these obligations not from any express language ordering new state funding, but by implication from the following subsections of § 6010:

> (1) Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities.
>
> (2) The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the development potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.

In the Court of Appeals' view, these declarations were sufficient to impose on the States an enforceable obligation to meet such objectives, regardless of feasibility or cost.

The fundamental flaw in this analysis is its failure to recognize that a declaration of rights and an affirmative obligation to fund their enjoyment are two different things. Unlike many federal rights (such as prohibitions against discrimination), the rights recognized by the Court of Appeals do not simply *limit* state action, but require the provision of services.[21] The central question, then, as the dissent below recognized, 163a; 612 F.2d at 117, is whether Congress not only identified these general rights but also imposed the legal duty to fund them. *See Cannon* v. *University of Chicago*, 441 U.S. 677, 730 n.1 (1979) (Powell, J., dissenting) ("[i]n the context of legislation enacted by Congress, the legal requirement involved is a statutory duty"). Clearly Congress did not

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[21] This basic distinction was critical to the decision in last Term's Abortion Cases. *See* Harris v. McRae, 48 U.S.L.W. 4941, 4947 (June 30, 1980) ("Although the liberty protected by the Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom").

take that responsibility on itself, as it is undisputed that the limited funds allotted under the Act could hardly be deemed adequate to meet this enormous burden.[22] And, as we discuss below, it is equally clear that Congress did not implicitly place this massive obligation on the States.[23]

As Chief Judge Seitz properly explained in dissent, "[t]he broad rights declared in section 6010 can be given concrete meaning . . . only by reference to the other provisions in the Act." 168a; 612 F.2d at 119. Read in this fashion, § 6010 is clearly part of a comprehensive funding statute, designed to assist and encourage the States to improve treatment for the developmentally dis-

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[22] For the fiscal year ending September 30, 1979, Congress allocated $55 million for implementation of the Act nationally. 42 U.S.C. § 6061. Of that sum, Pennsylvania received only $1.6 million. Pennhurst alone—which has received no DD Act monies—cost more than $27 million to operate in 1976. There can be little doubt that implementation of the relief below solely at Pennhurst—let alone statewide—would cost many times the $1.6 million provided by Congress to Pennsylvania. Indeed, the operation of the Special Master's Office alone has already cost that much. *See* note 14, *supra*. It is significant in this regard that, while Congress recognized the substantial costs of mass deinstitutionalization, *see* H.R. Rep. No. 58, 94th Cong., 1st Sess. 8 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 919, 926, it did not designate any monies for implementation of the Bill of Rights section of the Act. H.R. Conf. Rep. No. 473, 94th Cong., 1st Sess. 26 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 943, 945; *see also* 121 Cong. Rec. 29,818 (Sept. 23, 1975).

[23] When Congress has intended that the States fund certain entitlements, it has proved capable of saying so clearly. *See, e.g.*, King v. Smith, 392 U.S. 309, 333 (1968) (Social Security Act creates "a federally imposed obligation [on the States] to furnish 'aid to families with dependent children . . . with reasonable promptness to all eligible individuals . . .'") (quoting 42 U.S.C. § 602(a)(9)). Moreover, under such circumstances, Congress typically makes a far more substantial contribution to defray costs. *See, e.g.*, Harris v. McRae, *supra*, 48 U.S.L.W. at 4944 (Medicaid statute not "a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to fund").

abled, not an additional (and perhaps inconsistent) basis of state obligations. Alternatively, if § 6010 was intended to compel funding support for certain rights, the scope of that obligation is limited by the specific provisions of § 6010(3).

A. The DD Act Is A Funding Statute Designed To Assist And Encourage Improved State Care For The Developmentally Disabled.

A careful reading of the DD Act, its legislative history, and its implementing regulations all demonstrate that, far from requiring the States to fund new individual rights, the statute had a systemic focus, seeking to improve care for individuals by encouraging state planning, coordination and demonstration projects. Thus, the express "overall purpose" of the Act is:

> to *assist* States to assure that persons with developmental disabilities receive the care, treatment, and other services necessary to enable them to achieve their maximum potential through a system which coordinates, monitors, plans, and evaluates those services and which ensures the protection of the legal and human rights of persons with developmental disabilities.

42 U.S.C. § 6000(b)(1) (emphasis supplied).[24] To achieve

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[24] Its "specific purposes" are to "assist" and/or financially "support" various activities necessary to the provision of comprehensive services to the developmentally disabled. *See* 42 U.S.C. § 6000(b)(2). The governing regulations initially adopted by the Department of Health, Education and Welfare and modifications currently proposed by the Department of Health and Human Services fully support this view. *See* 45 C.F.R. § 1385.1 ("improve and coordinate the provision of services"); 45 Fed. Reg. 31,007 (May 9, 1980) ("the goal of the program is to enable States to increase the provision of quality services to persons with developmental disabilities. The goal is to be reached through the design and implementation of a comprehensive and continuing state plan which makes optimal

this purpose, the Act addresses three complementary, but separate, areas. First, it provides funding to assist the States in establishing "a system to protect and advocate the rights of persons with developmental disabilities." 42 U.S.C. § 6012.[25] Next, it authorizes separate funding to university-affiliated facilities for the operation of demonstration and training programs. 42 U.S.C. §§ 6031 *et seq.* Finally, it provides federal grants to participating States on condition that those States submit an overall plan satisfactory to the Secretary of Health and Human Services. 42 U.S.C. § 6063(a).

Although the Court of Appeals held that by accepting any funds under the Act, the States had bound themselves to underwrite the obligations the court read into § 6010, the Act itself imposes far more moderate obligations. The Secretary is required to approve state plans so long as they are in compliance with the general conditions outlined in 42 U.S.C. § 6063(b), which relate primarily to the use of funds allocated under the Act, as well as to the planning and coordination of services for the developmentally disabled.[26] While § 6063(b) includes certain

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use of Federal, State, local and private resources, and assures the rights and dignity of all those being served").

The Civil Rights Division of the United States Department of Justice, as intervenor in this and other cases, apparently takes a contrary view of the statute. See notes 8, 12, *supra*. But that Department is not charged with implementing the DD Act, and, consequently, its views are entitled to no special weight.

[25] Floor comments by Senator Kennedy indicate, as may be inferred from the Act itself, that the advocacy systems were to protect rights already established under the Constitution, as well as under other federal statutes—such as Medicaid and Social Security—and state law. 124 Cong. Rec. S 15,663 (daily ed. Sept. 21, 1978). *See also* H.R. Rep. No. 1188, 95th Cong., 2d Sess. 7 (1978), *reprinted in* 6 [1978] U.S. Code Cong. & Ad. News 7312, 7362.

[26] For example, a State's plan must provide for the establishment of a State Planning Council. 42 U.S.C. § 6063(b)(1). The plan must also set out its specific objectives, and the programs and re-

substantive standards to be satisfied by specific programs and institutions serving the developmentally disabled, 42 U.S.C. § 6063(b)(5), those standards not only are less stringent than the requirements imposed by the Court of Appeals, but also are applicable only to programs and facilities that—unlike Pennhurst—receive funds under the Act.

The distance between the obligations imposed by the Court of Appeals and the requirements of the Act can be seen at several points. For example, as plaintiffs' experts made clear, it is undisputed that a detailed individualized habilitation plan is a prerequisite to effective treatment.[27] *See* Roos, Tr. 1-118; Clements, Tr. 2-79. Yet, in a statute that the Court of Appeals read to impose an obligation to provide habilitation for all developmentally disabled persons, Congress required the provision of habilitation plans "only when the Federal Assistance under the Act contributes a portion of the cost of the habilitation services to the developmentally disabled person." H.R. Conf. Rep. No. 473, 94th Cong., 1st Sess. 43 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 943, 963 (1975); *see* 42 U.S.C. § 6011(a). If the Court of Appeals' view were correct, of course, there would be no purpose for Congress to have required habilitation plans at all, or to have limited the requirement to

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sources to be used in reaching those objectives. Additionally, the State must specify the extent and scope of services being provided under other state plans for federally assisted state programs for the developmentally disabled. *See generally* 42 U.S.C. § 6063(b) and pp. 24-32, *infra*.

[27] A habilitation plan sets forth the long-term habilitation goals for a developmentally disabled person and the intermediate habilitation objectives relating to the attainment of those goals. The plan also states, in some detail, the manner in which those objectives will be achieved. *See* 42 U.S.C. § 6011(b).

certain programs, since such plans automatically would have been mandated in all programs by the more inclusive requirements of § 6010.

The court's ruling is likewise incompatible with the specific condition imposed in § 6063(b)(5)(C),[28] which requires a state plan to assure the Secretary of HHS that the

> human rights of all persons with developmental disabilities (especially those persons without familial protection) *who are receiving treatment, services, or habilitation under programs assisted under this chapter* will be protected consistent with section 6010 of this title . . . .

(Emphasis supplied.) *See also* 45 C.F.R. § 1386.1(b)(5)(vi). Once again, these limitations—both as to "programs *assisted* under [the Act]," and as to affording protection in a manner that is "*consistent* with section 6010"—would be unnecessary if, as the court below ruled, *all* state programs had to provide funds to assure full effectuation of the rights described in § 6010.

It is thus apparent that the "findings" in § 6010, viewed in the context of the more specific provisions of the Act, represent generalized statements of policy, not newly created legal duties.[29] When Congress intended to impose discrete legal obligations on specific programs,

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[28] This provision was added in 1978, replacing § 6063(b)(24) of the 1975 Act, which required a similar "assurance."

[29] Nor is the contrary proved by a 1978 amendment to § 6010, which provides: "The rights of persons with developmental disabilities described in findings made in this section are in addition to any constitutional or other rights otherwise afforded to all persons." This statement, adopted without any legislative history, merely expresses Congress' view that persons with developmental disabilities have rights in addition to those generally available to "all persons." Nothing in this language, however, supports an inference of substantive duties from a statement of congressional policy.

namely, those funded under the Act, it did so in clear terms. *See* §§ 6011; 6063(b)(5)(C). Certainly Congress would not explicitly condition the receipt of federal funds on satisfying limited obligations in specified programs if these obligations were already imposed on all programs by the far more demanding requirements of § 6010.[30]

Like the Act itself, its legislative history discloses a Congressional intent to encourage, rather than mandate, the provision of better services to the developmentally disabled. Decrying the patchwork of overlapping programs and gaps that it viewed as diluting its funding efforts, Congress sought to coordinate programs of aid to the developmentally disabled. *See* H.R. Rep. No. 58, 94th Cong., 1st Sess. 21-23 (1975) (letter of February 19, 1975 from HEW Secretary Weinberger), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 919, 939-41; 121 Cong. Rec. 16,514-15, 29,818 (June 2, 1975; September 23, 1975) (comments of Senator Randolph); 121 Cong. Rec. 9,977 (April 10, 1975) (comments of Representative Carter).[31] The mechanism it chose to effectuate

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[30] The Court of Appeals' effort to impose new substantive obligations on the basis of general phrases in § 6010 is further undermined by examining other statutory language in that same section. For example, § 6010(2) also provides that "treatment, services, and habilitation . . . should be designed to *maximize* the developmental potential of the person" and § 6010(4) states that "[a]ll programs for persons with developmental disabilities should meet standards which are designed to assure the *most favorable possible outcome* for those served." (Emphasis supplied). The statements can hardly be transformed into enforceable obligations. Aside from the obviously complex and subjective questions of medical judgment posed by such "requirements," only in a world of limitless funding could they have any meaning whatsoever. As goals, however, much like the other provisions of the Bill of Rights, these provisions may properly be viewed as hopeful statements by an optimistic Congress.

[31] Similarly, in 1978 floor comments, Senator Kennedy declared:

> Since the inception of the Act in 1970, the DD program has attempted to bring together a variety of agencies tra-

this goal was funding incentives, not unconditional treatment requirements. Accordingly, the House Committee recognized that the Act was to be a "catalyst" intended to promote "effective planning by the states of their programs, initiation of new, needed programs, and filling of gaps among existing efforts." H.R. Rep. No. 58, 94th Cong., 1st Sess. 6, 21 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 919, 924. *See also* S. Rep. No. 160, 94th Cong., 1st Sess. 1, 33, 38 (1975).

One objective that Congress initially sought to foster was increased deinstitutionalization.[32] *See, e.g.*, 121 Cong. Rec. 16,516-17 (June 2, 1975) (comments of Senator Williams); *id.* at 16,518 (comments of Senator Javits); *id.* at 9,976 (April 10, 1975) (comments of Representative Carter). But Congress nevertheless recognized that community care was a "trend" to be promoted, not inflexibly imposed without regard to existing state programs. 121 Cong. Rec. 9,978 (April 10, 1975) (comments of Representative Biaggi); H.R. Rep. No. 58, 94th Cong., 1st Sess. 8 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 919, 926. Accordingly, the House Report stressed that the 1975 version of the Act required States to "plan for as much deinstitutionalization *as is feasible*," recognizing that this requirement would "*prompt some movement* of patients from State

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ditionally serving disabled people *to develop a coordinated and comprehensive service delivery system for its target population.*

124 Cong. Rec. S 15,671 (daily ed. Sept. 21, 1978) (emphasis supplied).

[32] By 1978, when considerably more deinstitutionalization had taken place, Congress authorized the States to shift away from this focus if they so desired. *See* pp. 21-22, *infra*. In this regard, it should be noted that, as even plaintiffs' witnesses recognized at trial, Pennsylvania was a leader in the area of deinstitutionalization. Glenn, Tr. 6-51, 69.

institutions back into their communities." H.R. Rep. No. 58, 94th Cong., 1st Sess. 8 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 919, 928 (emphasis supplied). *See also* S. Rep. No. 160, 94th Cong., 1st Sess. 1, 33, 38 (1975).[33]

The Bill of Rights section itself was a "compromise" between the House version, which had no such section, and the Senate version, which contained detailed program standards for institutions as well as for community settings. *See* H.R. Conf. Rep. No. 473, 94th Cong., 1st Sess. 41, 43 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 943, 961, 963. Significantly, the Senate version contained specific funding sanctions for failure to implement these detailed standards. S. 462, tit. II, § 206. *See* S. Rep. No. 160, 94th Cong., 1st Sess. 35 (1975).[34] The final version, by contrast, provides no such sanctions for failure to implement the Bill of Rights. By eliminating these sanctions, Congress made clear that the provisions of § 6010 were intended to be hortatory, not mandatory.

The detailed programmatic standards of S. 462, moreover, reflected the Senate's concern with past institutional abuses; they were not viewed as definitive federal treatment requirements to be forced on the States.[35] *See, e.g.*,

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[33] Senator Williams, a conferee on H.R. 4005, declared, "[w]e will be sending to the President today a bill which . . . will *assist* in the process of deinstitutionalization and the protection of the rights of persons with developmental disabilities." 121 Cong. Rec. 29,821 (September 23, 1975) (emphasis supplied).

[34] These penalties were not limited to funds received under the DD Act, but rather required the termination of all funding from the Federal government to a State found to be out of compliance. S. 462, tit. II, § 206; S. Rep. No. 160, 94th Cong., 1st Sess. 35 (1975). This would have included extensive federal funding under Medicaid.

[35] The hundreds of pages of program standards contained in the bill were described by the Senate Committee as only "the *beginning* of a goal we all seek—treatment and care of developmentally dis-

121 Cong. Rec. 16,516 (June 2, 1975) (comments of Senator Stafford); *id.* at 16,517 (comments of Senator Williams). To the extent that these concerns were ultimately reflected in the Bill of Rights, *see* 121 Cong. Rec. 29,820 (September 23, 1975) (comments of Senator Javits), they thus provide no basis for the approach adopted by the court below. Rather, as Senator Javits, sponsor of both the detailed standards of S. 462 and the Bill of Rights itself, made clear, the Bill was a statement of "federal policy," not a rigid declaration of enforceable duties. *Ibid.*[36]

Finally, the ruling below is directly at odds with a 1978 amendment to the Act requiring States to target federal funds received under its terms for at least one, but no more than two, of four specified areas of priority services. 42 U.S.C. § 6063(b)(4)(A)(ii). The priority areas include not only "alternative community living arrangement [CLA] services," but also individualized "case management services," "child development services," and "nonvocational social-developmental services," as well, each of which is significant in any system of care for developmentally disabled persons. 42 U.S.C. § 6001(8)(B). Congress assigned no special value to alternative CLA services in this four-area field.[37] Rather, consistent

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abled individuals which is humane, healthful, and appropriate." S. Rep. No. 160, 94th Cong., 1st Sess. 38 (1975) (emphasis supplied).

[36] Likewise, in committee hearings, legislators repeatedly asked for testimony on the expected effect of the Bill of Rights as a "model," not as a set of substantive duties. *See* Rehabilitation Amendments of 1978: Hearings on S. 2600 Before the Subcomm. on the Handicapped of the Senate Comm. on Human Resources, 95th Cong., 2d Sess. 293, 297 (1978) (questions of Senators Randolph and Stafford).

[37] To the contrary, this amendment replaced a provision in the 1975 Act specifically requiring that a State "earmark" 10 percent of its funds for deinstitutionalization expenditures in 1976 and

with its expressed desire that the States retain control of and flexibility in their delivery of services to the developmentally disabled,[38] Congress allowed participating States broad discretion to set their own budget priorities and to concentrate their resources in areas other than CLAs and deinstitutionalization. These aspects of the Act, and their legislative history, flatly contradict the holding of the court below that the DD Act requires the immediate creation of new CLAs in order to effectuate large scale deinstitutionalization.[39]

In sum, despite the broad language of § 6010, it is apparent that Congress did not intend to require the

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30 percent in succeeding years. 42 U.S.C. § 6062(a)(4) (1975) (repealed 1978). *See* H.R. Conf. Rep. No. 473, 94th Cong., 1st Sess. 32-33 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 943, 952. Moreover, other amendments included in the 1978 Act deleted the references to deinstitutionalization that had been contained in the 1975 Act. *See, e.g.*, § 6063(b)(20), (23) (1975) (repealed 1978).

[38] Describing the advantages of this requirement, the House Committee stated that:

> First, it leaves the individual States some flexibility to choose the service areas in which Federal dollars are most needed while, at the same time, requiring each participating jurisdiction to focus the federally supported activities on clear attainable service goals. Second, it establishes a viable relationship between the service objectives of a State's plan and the Federal aid available to help meet these objectives, thus avoiding unrealistic expectations which cannot be fulfilled. Third, it permits an orderly expansion of the program as Federal support increases in future years. . . . Finally, . . . it should be considerably easier for Congress and administration officials to evaluate the national impact of the program in future years.

H.R. Rep. No. 1188, 95th Cong., 2d Sess. 10 (1978), *reprinted in* 6 [1978] U.S. Code Cong. & Ad. News 7355, 7364-65 (1978).

[39] Ironically, during this same period, Pennhurst received substantial federal funding under the Medicaid program. *See* note 43, *infra*. Such funding was not readily available for non-institutional care, thus impeding creation for CLAs. Conley, Tr. 12-29. *See also* Brief of the United States (below) at 37 n.37.

States to provide funding for a panoply of new federal rights. As this Court has previously recognized, "Congress sometimes legislates by innuendo, making declarations of policy and indicating a preference while requiring measures that though falling short of legislating its goals, serve as a nudge in the preferred directions." *Rosado* v. *Wyman*, 397 U.S. 397, 413 (1970). This is what Congress did in the DD Act.[40]

B. If § 6010 Creates Enforceable Obligations The Substance Of Those Obligations Is Defined By The Provisions Of § 6010(3).

Even if, contrary to our preceding argument, the Bill of Rights is viewed as imposing affirmative obligations on the States, the question of the scope of those obligations still remains.[41] Although the Court of Appeals be-

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[40] The well-settled distinction between Congressional "encouragement" of state programs and the imposition of binding obligations on the States was recently stressed by this Court in a case raising very similar issues to the instant one. Southeastern Community College v. Davis, 442 U.S. 397 (1979). Construing § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, which bars discrimination against handicapped persons in federally-funded programs, the Court rejected a claim that a nursing school had to take affirmative steps to eliminate problems raised by an applicant's hearing disability. Finding that "state agencies such as Southeastern are only 'encourage[d] . . . to adopt such policies and procedures[,]' " 442 U.S. at 410 (quoting the Act), the Court stressed that "Congress understood [that] accommodation of the needs of handicapped individuals may require affirmative action and knew how to provide for it in those instances where it wished to do so." *Id.* at 411. Likewise in this case, Congress was aware of the needs of developmentally disabled persons and plainly understood the difference, financial and otherwise, between encouraging a specified type of treatment and mandating it.

[41] We should also point out that if § 6010 is read to create substantive rights to government-funded entitlements, there is no basis for imposing the costs on the States, rather than on the Federal government itself. As noted in this section, § 6010(3) details the obligations of *both* the Federal and State governments to monitor the use of "public funds"; and §§ 6010(1), (2) and (4) do not differentiate between any duties owed by the States as distinguished

lieved that the obligations mirror the general language of § 6010(1) and (2), we think that the guiding standards may more properly be found in the specific provisions of § 6010(3).

Unlike subsections (1) and (2) of § 6010, which are cast generally in terms of rights and objectives, the language of subsection (3) at least speaks directly to the matter of government obligations.[42] Thus, it says that both the Federal and State governments have an "obligation to assure that public funds are not provided to any institutional or other residential program" that does not either provide "appropriate treatment" or meet certain designated standards relating to matters such as proper diet, medical care, and fire and safety requirements. To the extent that § 6010 is read to impose enforceable obligations, therefore, this language necessarily must determine their scope. Any other view would make the requirements of § 6010(3) meaningless.

This precise approach was recently adopted in *Kentucky Ass'n for Retarded Citizens* v. *Conn*, No. C-78-0157LA (W.D. Ky. March 21, 1980). (R.M. 1a). Specifically rejecting the reasoning of the Court of Appeals in this case, the Kentucky court explained:

> Congress, in enacting 42 U.S.C. Sec. 6010(1) and (2), seemed to be explicit in its finding that persons

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from the Federal government. Congress made plain, moreover, that in enacting the DD Act it was entering "a partnership with the state[s] . . ." 121 Cong. Rec. 29,818 (September 23, 1975) (remarks of Senator Randolph). Thus, rather than having been an intervening plaintiff in this case, the United States should, if anything, have been a defendant, putting its resources behind its bold declaration of rights, as would a true partner. We note in this regard that the United States has been far less hospitable to such rights when it has been required to fund—rather than simply espouse—them. *See* Dixon v. Weinberger, 405 F.Supp. 974 (D.D.C. 1975).

[42] It is plain that, to the extent these obligations are enforceable, they authorize nothing more than a cut-off of federal funds. This power is already provided to HHS under the detailed provisions of § 6063. *See* page 31, *infra*.

> with developmental disabilities have a right to appropriate treatment and habilitation for those disabilities, and that the treatment and habilitation should be designed to maximize the development potential of the person in the setting that is least restrictive of his personal living. However, 42 U.S.C. Sec. 6010(3) qualifies or makes more specific the obligations of the federal government and the state, and, in essence, requires them to make certain that public funds do not flow to any institution or other residential program for the mentally retarded that either does not provide treatment and habilitation appropriate to the needs of such persons, or does not meet six specific minimum standards.

R.M. 26a. The court thus concluded that the substance of the obligations imposed on the States by § 6010 was defined by the concrete requirements of § 6010(3), and not the generalized declarations of § 6010(1) and (2).

While still exceeding the Congressional mandate, this view comes much closer to reflecting the limited purposes of the Bill of Rights than the one adopted by the court below. Recognizing that the obligations stated in § 6010 (3) were modest in nature, Congress made clear that they were *not* meant to be definitive but, rather, were to be augmented by standards imposed in *other* legislation:

> The conference committee recognizes that six minimum standards are designed to protect the *basic human needs of developmentally disabled individuals and will not in themselves ensure quality habilitation and adequate treatment programs.* The committee therefore does not intend these standards to preempt or supplant any existing Federal or State standards currently in force (*e.g.*, standards applicable to Intermediate Care Facilities for the Mentally Retarded under Medicaid), which may require more detailed or higher standards of care.

121 Cong. Rec. 29,820 (September 23, 1975) (emphasis supplied). This view is patently inconsistent with the approach taken by the court below. Hence, at most, the Bill

of Rights was intended to establish minimal requirements to supplement other state and federal standards in this area.[43]

The Court of Appeals in this case relied on subsection A of § 6010(3) which refers to "appropriate treatment, services, and habilitation", to support its conclusion that the Act creates an individual right to treatment. *See* 110a-111a; 612 F.2d at 95-96. This reliance was misplaced. Initially, the court failed to recognize that § 6010(3) speaks not in terms of individual rights, but rather in terms of standards generally applicable to "institutional or other residential programs," thus again stressing Congress' systemic concerns.[44] Moreover, the section requires facilities to provide appropriate treatment "*or*" to comply with six specific criteria; hence, its terms can be satisfied in *either* fashion.[45] Finally, far

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[43] In this regard, it should be noted that Pennhurst receives extensive funding under the Federal Medicaid statute—more than $6 million of the $27 million needed to operate it in 1975-76 (Rice, Tr. 26-14). That statute imposes detailed program standards on recipient facilities. *See* 42 U.S.C. § 1396a; 42 C.F.R. §§ 442.400 *et seq.*

[44] Section 6010(3), which obviously contemplates institutional placements, does not even mention the right to the least restrictive environment.

[45] As the court explained in Kentucky Ass'n for Retarded Citizens v. Conn, *supra*, R. M. 26a-27a:

> When paragraphs (1), (2) and (3) of 42 U.S.C. Sec. 6010 are fully examined, it seems fair to state that Congress contemplated that . . . the programs which are provided [under the Act] must either provide appropriate treatment and habilitation or meet the six standards referred to in paragraphs (3)(B)(i) through (vi) . . . . [I]t would seem that Congress realized that there might even be situations where a developmentally disabled person would not have to be furnished treatment and habilitation as such, but would have to be pro-

from imposing a right to state-funded treatment, § 6010(3) simply restricts the use of federal monies to those programs that satisfy the specified conditions.[46] In short, rather than supporting the Court of Appeals' view of the duties imposed by the Bill of Rights, § 6010(3) is plainly incompatible with that view.[47]

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vided with custodial care according to minimum standards such as proper diet, appropriate medical services, proper safety compliance, and prohibition of the use of physical restraint.

[46] The statutory proscription of § 6010(3) refers to the use of "public" funds and thus is ambiguous as to whether it applies to state as well as federal funds. Section 6062(a)(1)(C), however, indicates that Congress' concern was limited to "[s]ums allotted to the States under [the DD Act]." Likewise, in construing the Social Security Act, this Court made plain that Congress "of course, in no way prohibited [a State] from using only *state* funds according to whatever plan it chooses. . . ." Rosado v. Wyman, 397 U.S. 397, 420 (1970) (emphasis in original).

[47] We should further point out that even if § 6010 is read as imposing new obligations, not limited by the specific proscriptions of § 6010(3), there is no basis for finding a right to the least restrictive environment under § 6010(2). In contrast to § 6010(1), which states that developmentally disabled persons have a "right to appropriate treatment," § 6010(2) states only that such treatment "*should* be provided in the setting that is least restrictive of the person's personal liberty." (Emphasis supplied.) The use of the hortatory "should," when coupled with the 1978 amendment to the DD Act eliminating any requirement for creating CLAs, *see* pp. 21-22, *supra*, plainly demonstrates that even if Congress intended to require States to fund treatment, it imposed no requirement concerning the setting—community or institutional—in which such treatment was to be provided. On this basis alone, the decision below must be reversed.

II. THE SECRETARY OF HEALTH AND HUMAN SERVICES HAS EXCLUSIVE AUTHORITY TO ENFORCE ALL SUBSTANTIVE DUTIES IMPOSED BY THE DD ACT.

Assuming, *arguendo*, that § 6010 imposes legally binding obligations on the States, it still must be decided whether those obligations can be enforced by the plaintiffs to this action.[48] "[I]t is for Congress to determine how the rights which it creates shall be enforced." *Switchmen's Union of North America* v. *National Mediation Board*, 320 U.S. 297, 301 (1943). The Court of Appeals, purporting to rely on the analysis established by *Cort* v. *Ash*, 422 U.S. 66 (1975), held that developmentally disabled persons have a private right of action to enforce § 6010 in federal court. In our view, this conclusion is incompatible with the enforcement scheme carefully designed by Congress. That scheme grants to the Secretary of HHS exclusive responsibility for enforcing all obligations imposed on the States by the Act.

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[48] In its June 9, 1980 order granting certiorari, the Court instructed the parties to address the following question:

> Does 42 U.S.C. § 1983 provide a private remedy to enforce the provisions of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000 *et seq.*?

We address that issue here. We should note at the outset, however, that § 1983 is solely a remedial statute, providing a cause of action but creating no substantive rights. *See, e.g.*, Chapman v. Houston Welfare Rights Organization, 441 U.S. 600, 618-20 (1979). Hence the § 1983 issue need not be reached unless and until it is determined which (if any) federal rights are "secured" by the DD Act. *See, e.g.*, Southeastern Community College v. Davis, *supra*, 442 U.S. 397; Carter v. Greenhow, 114 U.S. 317 (1885). Indeed, if we are correct that the Act does not impose the obligations read into it by the court below, the "private remedy" issue need not be reached at all. *See* Southeastern Community College v. Davis, *supra*, 442 U.S. at 404 n.5.

Last Term, in *Maine* v. *Thiboutot*, *supra*, 48 U.S.L.W. at 4860, this Court ruled that 42 U.S.C. § 1983 provides a private right of action for state "deprivation[s] of any rights, privileges, or immunities secured by [all] . . . laws [of the United States]."[49] At the same time, however, it was recognized that an exception to the broad rule would apply "in cases where the governing statute provides an exclusive remedy for violations of its terms." *Maine* v. *Thiboutot*, *supra*, 48 U.S.L.W. at 4865 n.11 (Powell, J., dissenting). *See also Chapman* v. *Houston Welfare Rights Organization*, 441 U.S. 600, 672 (1979) (White, J., concurring) (§ 1983 not applicable when there is "clear indication in a particular statute that its remedial provisions are exclusive or that for various other reasons a § 1983 action is inconsistent with congressional intention"); *Preiser* v. *Rodriguez*, *supra*, 411 U.S. 475 (habeas corpus); *Adickes* v. *S.H. Kress & Co.*, 398 U.S. 144, 150 n.5 (1970) (public housing act). The need for such an exception is apparent, for otherwise Congress would be unable to establish cooperative federal-state programs with a specified means of review and enforcement, without automatically opening the federal courts to private suits against the participating state officials.

This exception applies with full force here. Except for § 6010, every other section of the statute that could even arguably be read as imposing a duty on the States specifies either that "the *Secretary* shall require" compliance, *e.g.*, §§ 6005, 6011 (emphasis supplied); *see generally* § 6063, or directs the State to create a specific adminis-

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[49] This ruling obviates the need to employ the four-part analysis established in Cort v. Ash, 422 U.S. 66 (1975). The *Cort* analysis would appear to remain applicable to consideration of private remedies for enforcing deprivations of federal rights in cases not involving state action.

trative agency, *see* §§ 6012, 6067.[50] And while § 6010 contains no specific enforcement provision, § 6063(b)(5)(C) makes clear that its enforcement rests with the Secretary:

> The [state] plan must contain or be supported by assurances satisfactory *to the Secretary* that the human rights of all persons with developmental disabilities (especially those persons without familial protection) who are receiving treatment, services, or habilitation under programs assisted under this chapter will be protected consistent with section 6010 of this title (relating to rights of the developmentally disabled).

(Emphasis supplied). Hence, Congress explicitly decided how it wanted to enforce the concerns reflected in § 6010.[51]

The Act, moreover, arms the Secretary with a variety of monitoring mechanisms so that she may be kept advised of information directly relevant to these Congressional concerns. Under § 6009(a), each State must submit a plan for implementing a comprehensive system

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[50] There is no claim here that Pennsylvania was deficient in establishing the requisite agencies. In any event, enforcement of such requirements through private actions would hardly seem appropriate, especially where the statute charges the Secretary with reviewing and overseeing these agencies. *See* §§ 6012(a), 6063(b). *Cf.* Securities Investor Protection Corp. v. Barbour, 421 U.S. 412 (1975); Nat'l RR Passenger Corp. v. Nat'l Ass'n of RR Passengers, 414 U.S. 453 (1974).

[51] It is clear that the Secretary takes this responsibility seriously. Thus, in recently proposed regulations, HHS stated:

> The Department has decided to require that all programs authorized under the Act . . . comply with Sec. 111 [§6010] of the Act. . . . Recipients of funds under the Act are to assure the State and the Commissioner that they will provide services which comply with the requirements of Sec. 111 (Rights). Failure to comply with the assurance may result in the loss of Federal funds.

45 Fed. Reg. 31,006 (May 9, 1980).

developed by HHS and designed to evaluate services provided under state programs funded through the Act. *See* 45 C.F.R. § 1385.11. This state evaluation system is required to provide objective measures of developmentally disabled persons' progress, relying on data obtained from individualized habilitation plans, *see* § 6011, and to assess service programs by their effectiveness in habilitating such persons. *See* § 6009(b). The Secretary also receives reports from the State Planning Councils, § 6067(b)(4), which are required to "monitor, review, and evaluate, not less often than annually, the implementation of [the] State plan," § 6067(b)(2), and "to the maximum extent feasible [to] review and comment on all State plans in the State which relate to programs affecting persons with developmental disabilities. . . ." § 6067(b)(3). *See also* 45 C.F.R. § 1386.24. Similarly, the State Protection and Advocacy systems mandated by § 6012 must report to the Secretary regarding their efforts in protecting the rights of the developmentally disabled.

The Act further provides effective procedures and appropriate sanctions to ensure State compliance with its dictates. The Secretary may disapprove a state plan only after "reasonable notice and opportunity for a hearing to the State." § 6063(c). At that point, the Secretary may, but is not required to, cut off some or all of the funds provided under the Act to a noncomplying State. § 6065. Any State dissatisfied with either the Secretary's disapproval of the plan, or her decision to terminate funding, may appeal to the appropriate United States Court of Appeals. § 6068.

This enforcement approach allows for meaningful participation by concerned individuals. Thus, 45 C.F.R. § 1386.94(b)(1) explicitly provides that in a compliance hearing conducted by the Secretary,

> [o]ther individuals or groups may be recognized as parties, if the issues to be considered at the hearing have caused them injury and their interest is within the zone of interests to be protected by the governing Federal statute.

The Secretary is also entitled to assurances from participating States that developmentally disabled persons and their representatives have taken part in establishing the habilitation plans required in programs funded under the Act. §§ 6011, 6063(b)(5)(B). Similarly, State Councils mandated by the Act must include developmentally disabled persons or relatives of developmentally disabled persons. § 6067(a)(2), (3); 45 C.F.R. § 1386.61. Thus, the DD Act, while confiding its enforcement solely to the Secretary, incorporates various mechanisms to assure individual participation in the process.

The legislative history confirms this view of the Secretary's exclusive enforcement power. Senator Schweiker, a co-sponsor of the Act, specifically described § 6010 as a means "to provide for the rights of developmentally disabled individuals to treatment, services, and habilitation, maximization of their developmental potential, and protection *by denial of funds* to programs which do not provide appropriate treatment, services, and habilitation or meet appropriate standards." 121 Cong. Rec. 29,820 (September 23, 1975) (emphasis supplied). And Senator Stafford stressed that the Act "strengthens the administrative ability of the Department of HEW to protect the constitutionally guaranteed rights of institutionalized individuals." *Id.* at 29,819. In short, "Congress for reasons of its own decided upon the method for the protection of the 'right' which it created. It selected the precise machinery and fashioned the tool which it deemed suitable to that end." *Switchmen's Union of North America* v. *National Mediation Board*, *supra*, 320 U.S. at 301.

The addition of a private cause of action to enforce the Act would be incompatible with this carefully-crafted scheme.[52] Particularly where the supposed rights are as amorphous as a right to appropriate treatment and a right to the least restrictive environment,[53] it is

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[52] It is true that the Conference Committee report on the Act states "that the developmentally disabled . . . have a right to receive appropriate treatment for the conditions for which they are institutionalized, and that this right should be protected and assured by Congress and the courts." H.R. Conf. Rep. No. 473, 94th Cong., 1st Sess. 42 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 943, 961. This comment may sensibly be read to reflect congressional understanding that the courts would continue to protect constitutional rights and to enforce treatment standards imposed by *other* statutes, and that Congress, by funding commitments, would help provide as much additional treatment as feasible. *See* note 25, *supra*. It should be noted that in any case the statement does not authorize judicial enforcement by *private* individuals. On the contrary, it is fully compatible with the approach espoused before Congress by then-Assistant Secretary of HEW Kurzman, recognizing that the *Secretary* might need to seek recourse to the courts:

> [HEW's] role . . . is to set realistic enforceable standards, to require the States to conduct the kinds of surveys necessary within the facilities in those States and advise us as to the outcome of those surveys, to enforce through the States and under the medicaid program in the case of individual facilities which fail to meet those standards, or to meet the timetables for planning to meet those standards, by withholding the Federal funds, as we have done in the case of the skilled nursing facilities.
>
> In some instances, it is necessary to enforce by using the Federal courts. As you know, we have brought lawsuits against the State of Pennsylvania under the ICF-MR regulations, and I think that is a primary function.

Developmentally Disabled Assistance and Bill of Rights Act of 1975: Hearings on S. 462 Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare, 94th Cong., 1st Sess. 437-38 (1975).

[53] In this respect, it is important to note that the content of the rights is far different from the monetary entitlements traditionally provided under federal statutes—such as welfare or Medicaid—that this Court has held amenable to private enforcement.

far more sensible to allow the Secretary to secure reasonable and consistent compliance rather than to subject interpretation of these rights to the ad hoc determinations of federal courts.[54] *Cf. Great American Savings & Loan Ass'n* v. *Novotny*, 442 U.S. 366 (1979); *Brown* v. *General Services Administration*, 425 U.S. 820 (1976).

An exclusive remedy, moreover, empowers the Secretary to assure *systemic* compliance with the statutory requirements without opening the federal courts to individual claims by each of the more than two million persons covered by the Act. *See Naughton* v. *Bevilacqua*, 458 F.Supp. 610, at 614-17 (D.R.I. 1978), *aff'd in part*, 605 F.2d 586 (1st Cir. 1979) (damages action for alleged inappropriate treatment of one mentally retarded person). Nor is sensible enforcement of the statute likely to be frustrated by a lack of capacity or resources on the part of the Secretary, *compare Cannon* v. *University of Chicago*, *supra*, 441 U.S. at 708 n.42; *Allen* v. *State Board of Elections*, 393 U.S. 544, 556-57 (1969), since the number of state plans is limited and the statute specifically charges the Secretary with reviewing each state plan. *See also* n.51, *supra*.

III. EVEN ASSUMING THAT § 6010 IMPOSES PRIVATELY ENFORCEABLE STATE DUTIES THE COURT BELOW SHOULD HAVE LIMITED RELIEF TO ENJOINING FEDERAL FUNDING.

Having found that the DD Act creates privately enforceable rights to state-funded appropriate treatment

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[54] Compare the decision below with the district court decisions in Kentucky Ass'n for Retarded Citizens v. Conn, *supra*, and Naughton v. Bevilacqua, 458 F. Supp. 610 (D.R.I. 1978), *aff'd in part*, 605 F.2d 586 (1st Cir. 1979), each of which construes § 6010 differently. Similarly, the Court of Appeals for the Fourth Circuit in dicta limited enforcement of the rights under the Act to "a state judicial forum and not a federal judicial forum. . . ." United States v. Solomon, 563 F.2d 1121, 1125 (1977). *Cf. also* United States v. Mattson, 600 F.2d 1295, 1299-1300 (9th Cir. 1979).

and to the least restrictive environment, the Court of Appeals then proceeded to uphold the massive relief ordered by the district court.[55] In essence, this relief authorizes the district court (through the use of a Special Master and a Hearing Master) to determine the proper placement and services for each of the more than 1,000 residents of Pennhurst, as well as the many others covered in the class certified by the court, *see* note 4, *supra*, and to require the state and county governments to develop such placements and services, or to contract with private parties for them. *See also* note 14, *supra*. In mandating this relief the Court of Appeals went far beyond the permissible scope of its remedial powers. As this Court has made clear, a proper accommodation of state-federal interests—even in a program that truly involves joint funding—requires far less drastic relief.

The governing principles were recognized in *Rosado* v. *Wyman*, *supra*, where the Court found that New York's definition of "need" in calculating welfare payments was incompatible with the federal statute. Acknowledging the significant potential monetary implications of its ruling, the Court held that the welfare claimants were only "entitled to declaratory relief and an appropriate injunction by the district court against the payment of *federal* monies according to the new schedules, should the state not develop a conforming plan within a reasonable period of time." 397 U.S. at 420. The Court specifically rejected any suggestion that it could require New York to pay the additional sums demanded by compliance with the federal standards. Rather, relying on its earlier decision in *King* v. *Smith*, 392 U.S. 309 (1968), it explained that "the state ha[s] alternative choices of assuming the additional cost" of complying

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[55] As noted above, *see* page 6 & note 13, *supra*, the Court of Appeals vacated two aspects of that relief.

with the federal standard "or not using federal funds to pay welfare benefits according to a plan that [is] inconsistent with federal requirements." 397 U.S. at 420-21.[56]

These principles control here. As indicated above, *see* pages 23-27, *supra*, Congress' concern under the statute was to assure that *federal* funds were being used to promote certain desired policies and goals. *See* §§ 6010(3); 6062(a)(1)(C). It had no intention of authorizing a federal takeover of state care delivery systems, as § 6003 makes clear:

> Except as otherwise specifically provided, nothing in this chapter shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility for persons with developmental disabilities with respect to which any funds have been or may be expended under this chapter.

There are no "specific" provisions that would support the intrusions sanctioned below, and thus relief should have been restricted to a declaration of rights and an injunction against funding.[57]

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[56] The Court has not deviated from this approach in subsequent cases. While it is true that the judgment in Maine v. Thiboutot, *supra*, required the State to pay monies in accordance with federal welfare requirements, the Court was careful to note that the propriety of the relief was not in question since "[t]he State did not appeal the judgment against it." 48 U.S.L.W. at 4860 n.2.

[57] The Court of Appeals concluded that the obligations in the Bill of Rights were imposed pursuant to Congress' powers under the Spending Clause. *See* 118a-19a; 612 F.2d 99. In our view, if the statute is read to authorize relief beyond a fund cut-off, Congress exceeded the limits of that power. It is one thing to say that Con-

The need to so limit relief is even more compelling here than it was in *Rosado*. First, in the welfare area, the federal government is a true financial partner, assuming a substantial portion of the financial burden. *See King* v. *Smith*, *supra*. Under the DD Act, by contrast, its financial participation is extremely limited, seeking only to provide financial incentives to participating States. *See* note 22, *supra*. Surely if Congress cannot force the States to fund entitlements when it makes a substantial contribution, it should not be able to do so when its contribution is insubstantial.

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gress may make an "offer of benefits to a state . . . dependent upon cooperation by the state with federal plans," Oklahoma v. Civil Service Commission, 330 U.S. 127, 144 (1947); it is quite another to say that, once accepted even temporarily, the offer gives the Federal government continuing control over state programs in accordance with those conditions. If the latter proposition were correct, a State that misunderstood federal conditions, or underestimated their costs to its taxpayers, would nonetheless be locked into a federal program merely by its acceptance of federal funds. "This exercise of congressional authority does not comport with the federal system of government embodied in the Constitution." National League of Cities v. Usery, 426 U.S. 833, 852 (1976). We note, moreover, that to the extent the Court of Appeals predicated liability on state receipt of DD funds under the Act, it erroneously included in its judgment counties that never received such funds or received them only intermittently.

The court further suggested that the rights under the Act were imposed pursuant to Congress' power under § 5 of the Fourteenth Amendment. 117a; 612 F.2d at 98. In view of this Court's summary rejection of a constitutional right to treatment in the least restrictive environment, *see* Sanchez v. New Mexico, 396 U.S. 276 (1970), *dismissing for want of a substantial federal question* 80 N.Mex. 438, 457 P.2d 370 (1968); O'Connor v. Donaldson, 422 U.S. 563, 587-89 (1975) (Burger, C.J., concurring), such an exercise of congressional power would appear to be ill-founded. *Cf.* Oregon v. Mitchell, 400 U.S. 112 (1970); Katzenbach v. Morgan, 384 U.S. 641 (1966).

Second, in contrast to federal requirements under a welfare statute, which involve only cash payments, rights to "appropriate treatment" and the "least restrictive environment" involve delicate professional judgments as to appropriateness and restrictiveness. As this Court has recognized, courts are singularly ill-suited to make these determinations. Thus, in *Parham* v. *J.R.*, 442 U.S. 584 (1979), the Court stressed that "neither judges nor administrative hearing officers are better qualified than psychiatrists to render psychiatric judgments." 442 U.S. at 607, *quoting In Re Roger S.*, 19 Cal. 3d 921, 941, 141 Cal. Rptr. 298, 569 P.2d 1286, 1299 (1977) (Clark, J., dissenting). Likewise, Chief Judge Seitz, dissenting in this case, explained, "[W]hat is the least restrictive environment for any particular individual is primarily a medical question . . . [T]his concept is an uncertain one and has been the subject of fervent medical debate." 190a; 612 F.2d at 128.[58]

Moreover, the appropriateness of any given treatment, as well as the "least restrictive alternative for any particular individual will change over time. Thus, there is no single and final solution. . . ." *Ibid.*[59] As Congress

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[58] *See also* Bowring v. Godwin, 551 F.2d 44, 48 (4th Cir. 1977) ("we disavow any attempt to second-guess the propriety or adequacy of a particular course of treatment") (footnote omitted); Kentucky Ass'n for Retarded Citizens v. Conn, *supra*, R. M. 37a-38a ("whether or not to place a person in [an institution] and whether or not to continue his placement there is contingent upon the particular facts and circumstances surrounding that individual and his progress, and should be left to a decisionmaker such as the interdisciplinary team rather than in the hands of a court or court-appointed official").

[59] Nor, as Chief Judge Seitz further explained, can this analysis be "salvage[d] . . . by labelling community living arrangements as *the* least restrictive alternative." 190a; 612 F.2d at 128 (emphasis in original). As "the record indicates, . . . community living ar-

itself recognized, "persons with developmental disabilities often require specialized lifelong services to be provided by many agencies in a coordinated manner in order to meet the person's needs . . ." § 6000(a)(3). In short, affirmance of the relief imposed below would mean that "almost every decision concerning the care of a mentally retarded person would be subjected to ongoing judicial review." 190a; 612 F.2d at 128.

This Court has repeatedly stressed that federal courts should guard against assuming the authority for administering programs traditionally reserved to other authorities. *See Bell* v. *Wolfish*, 441 U.S. 520 (1979); *Rizzo* v. *Goode*, 423 U.S. 362, 378-80 (1976). Such caution is especially appropriate where the alternative of a cutoff of federal funds will fully protect the *legitimate* federal interests at stake. Thus, irrespective of the obligations imposed by the DD Act or the means provided for their enforcement, the relief authorized by the Court of Appeals must be reversed.

IV. STATE LAW PROVIDES NO RIGHT TO TREATMENT TO THE MENTALLY RETARDED.

After imposing a federal obligation on the States to provide treatment, the court below examined state law and found that it too imposes such a requirement.[60] 122a-130a; 612 F.2d at 100-03. In reaching that result, the court relied primarily on § 201,[61] which provides in pertinent part:

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rangements tend to be all things to all people." 191a n.5; *id.* at n.5 *See also* Gary W. v. Louisiana, 437 F.Supp. 1209, 1217-19 (E.D.La. 1976).

[60] The Mental Health and Mental Retardation Act of 1966, Pa. Stat. Ann. tit. 50, §§ 4101 *et seq.* (Purdon).

[61] The court also relied in part on the legislative debate of the state statute. 127a-29a; 612 F.2d at 102-03. Under Pennsylvania

> The Department [of Public Welfare] shall have power, and its duty shall be:
>
> > (1) To assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them, regardless of religion, race, color, natural origin, settlement, residence, or economic, or social status.

Pa. Stat. Ann. tit. 50, § 4201. The court found habilitation to be a mandated mental retardation service. This conclusion neither supports the judgment below, nor is it a correct interpretation of state law.[62]

Pennsylvania provides a broad spectrum of services to its mentally retarded citizens, ranging from programs designed to maintain the retarded in their natural homes, *e.g.*, 7 Pa. Bull. 1,430 (May 23, 1977), to community residences and to institutional care. The nature, extent, and manner of providing and funding those services is governed by the Mental Health and Mental Retardation Act of 1966.[63] That Act is clear that the responsibility to provide services is limited, as it must be, by the availability of appropriated funds. *County of Allegheny* v. *Commonwealth*, 33 Pa. Cmwlth Ct. 267, 381 A.2d 1014

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law, however, comments made on the floor of the legislature are irrelevant for purposes of statutory construction. Commonwealth v. Alcoa Properties, Inc., 440 Pa. 42, 46 n.1, 269 A.2d 748, 749 n.1 (1970); Martin Estate, 365 Pa. 280, 283, 74 A.2d 120, 122 (1950).

[62] Petitioner Pennhurst Parents-Staff Association joins only in those portions of this argument contending that state law does not support the judgment below.

[63] The counties provide community-based programs, generally with 90 percent funding. Pa. Stat. Ann. tit. 50, § 4509(1). The State directly provides and wholly funds institutional care. § 4507 (1). While CLAs are provided by the counties, they are 100 percent state-funded because they are considered a "new program." *See* § 4507(a)(2).

(1978). *See generally Harris* v. *McRae, supra,* 48 U.S.L.W. 4941. The court below recognized that the right to services could not be "unconditional." 127a; 612 F.2d at 102.[64] Thus, that court held only "that to the extent Pennsylvania maintains facilities for the mentally handicapped, those facilities must provide adequate treatment or habilitation." *Ibid.* It did not, however, find a state right to treatment in the least restrictive environment.[65] Nor did it limit relief to residents in those state-operated facilities.

Even this limited holding, not supported by any decision of any court of state-wide jurisdiction, misconstrues the statute. Under it, if faced with a 25 percent funding short-fall, state officials would be required to terminate all services to 25 percent of the mentally retarded. That result defies logic as well as the legislative mandate that the Department "assure . . . the *availability and equitable* provision of . . . mental retardation services for all persons who need them." Pa. Stat. Ann. tit. 50, § 4201(1) (emphasis supplied). *See also* Pa. Stat. Ann. tit. 50, § 4509(5).

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[64] In this regard, the court considered § 509(5) of the Act, which directs the State:

> In the event that sufficient funds to pay the full amount of the grants to which the counties may be entitled . . . have not been appropriated, to distribute State funds among the counties by a formula reasonably designed to achieve the objectives of this Act, provided however, that in such event the counties' financial obligations under this Act shall be reduced in accordance with the same formula *and the counties shall be required to provide only those services for which sufficient funds are available.*

Pa. Stat. Ann. tit. 50, § 4509(5) (emphasis supplied). 228a-29a.

[65] In Part VI of its opinion, 130a-141a; 612 F.2d at 103-08, in which it found such a right, the court relied solely on the DD Act. Thus, its state law holding was unnecessary and insufficient to support affirmance. *See* Murdock v. City of Memphis, 87 U.S. 429 (1875).

As importantly, the court failed to recognize that treatment is not the only basis for commitment of the retarded under state law. To the contrary, the mentally retarded may be committed when they are "in need of care or treatment." Pa. Stat. Ann. tit. 50, § 4406(a).[66] As both the legislature and Chief Judge Seitz recognized, the overriding majority of the retarded at Pennhurst are not "capable of surviving safely in freedom by [themselves]" nor do they have "willing and responsible family members or friends to provide the required care." 182a; 612 F.2d at 125, *quoting O'Connor* v. *Donaldson*, 422 U.S. 563, 576 (1975). Accordingly, the provision of care—"food, shelter, medical care and supervision for which the residents have no other source," *ibid.*—is the minimum statutory standard of services for the mentally retarded.

Finally, the Court further erred in concluding that § 201(1) imposed duties on the counties. That section is contained in Article II of the Act, entitled "Responsibilities of the State." In contrast, Article III of the Act, entitled "Responsibilities of Counties," and, in particular, § 301(d), govern the counties' obligation. Under § 301(a), Pa. Stat. Ann. tit. 50, § 4301(a), the counties are required to establish a mental retardation program. Section 301(d), in turn, establishes the required content of that program—nine mandated services ranging from emergency services to short-term inpatient care. The CLA program, established only in 1970, 176a; 612 F.2d at 122, is not among those nine statutorily mandated services. Instead, the CLA program is grounded in the State's authority to establish "new program[s]." § 4507(a)(2). Significantly, the counties' obligation to

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[66] In contrast, under a separate statute enacted in 1976, the mentally ill may be committed only when "severely mentally disabled and in need of treatment." Pa. Stat. Ann. tit. 50, § 7304(a). *See* Kremens v. Bartley, 431 U.S. 119 (1977).

provide even the nine mandated services is expressly subject to § 509(5), *see* note 64, *supra*.

Despite these limited statutory obligations, Pennsylvania has been extremely responsive to the needs of its mentally retarded citizens. As the Third Circuit itself noted just months before its decision in this case, Pennsylvania has allocated "an extraordinary large portion of its budget" to the mentally disabled. *Doe* v. *Colautti*, 592 F.2d 704, 711 (3d Cir. 1979). Further improvement and expansion of existing programs will continue. Clearly, however, Pennsylvania's present services for the mentally retarded do not violate state law.

CONCLUSION

The decision of the Court of Appeals should be reversed.

Respectfully submitted,

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IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1979

PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
Petitioners

v.

TERRI LEE HALDERMAN, *et al.*,
PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS,
et al.,
and
UNITED STATES OF AMERICA,
Respondents

ON PETITIONS FOR WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

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QUESTIONS PRESENTED

1. Was certiorari improvidently granted in view of recent proposed regulatory changes, enactment of the Civil Rights of Institutionalized Persons Act, P.L. 96 - 247, intervening decisions of the Court, the dispositive nature of state law, and the factual nature of the case?

2. Did the District Court and the Court of Appeals *en banc* reasonably and correctly interpret dispositive and definitive Pennsylvania statutory and case law providing an enforceable right to habilitation to the retarded?

3. In the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§6000 *et seq.*, did Congress grant retarded people an enforceable right to habilitation appropriate to the individual, with a remedy provided under either 42 U.S.C. 1983 or, alternatively, an implied private right of action?

4. Where undisputed and uncontradicted facts prove the abominable conditions in an institution for the retarded and prove that every person confined in the institution can and should be cared for in a continuum of less costly, more effective structured community settings, does a District Court have the equitable discretion, under the Developmentally Disabled Assistance and Bill of Rights Act, to prohibit further admissions and to require that the institution be replaced?

5. Where government officials adamantly refuse to remedy violations of rights and where protection of state and federal statutory rights would otherwise be impossible, does appointment of a master with circumscribed supervisory duties and the granting of relief tailored to the circumstances violate principles of federalism?

LIST OF PARTIES

The parties are adequately listed at pages ii through iv of Brief for Petitioners except that it is not there indicated that the private respondents sue on behalf of all persons similarly situated.

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Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§6000, *et seq.*: . . . 10, 23, 34, 36

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Mental Retardation Facilities and Community Mental Health Centers Construction Act, P.L. 88-164, 77 Stat. 282, 88th Cong. (1963) . . . 37, 38, 39

Mental Retardation Amendments of 1967, P.L. 90-170, 81 Stat. 527, 90th Cong. (1967), extended by P.L. 91-517, 84 Stat. 1316, 90th Cong., 1st Sess. (1969) 38, 47

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Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978, P.L. 95-602, 92 Stat. 2955 (1978) 38, 44

28 U.S.C. §1331 49

28 U.S.C. §1343(3) 49

28 U.S.C., F.R.Civ.Pro. 52(a) 6

28 U.S.C., F.R.Civ.Pro. 53 58

42 U.S.C. 1983 ..... 12, 23, 49, 53

45 Fed. Reg. 31006 20

45 Fed. Reg. 31014 20

Federal Legislative History:

Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973, Hearing before the Subcommittee on the Handicapped of the Committee on Labor and Public Welfare, U.S. Senate, on S.427 and S.458 . 39, 41, 42, 43, 44, 47

Developmentally Disabled Assistance and Bill of Rights Act, 1974, Hearings before the Subcommittee on the Handicapped of the Committee on Labor and Public Welfare, U.S. Senate, on S.3378 ..... 39, 40, 45, 47

Developmentally Disabled Assistance and Bill of Rights Act, 1975, Hearings before the Subcommittee on the Handicapped of the Committee on Labor and Public Welfare, U.S. Senate, on S.462 ..... 40, 48

Federal Legislative History: Page

Mental Retardation Amendments of 1967, Hearing before the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, on S.1099 and H.R.643 and S.389 . . 38

Mental Retardation and Other Developmental Disabilities, 1969, Hearings before the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, on S.2846 . 38

H.Conf.Rep. No. 94-473, reprinted, 1975 U.S. Code, Cong. & Ad. News 943 . 14, 40, 44, 47, 48, 50, 51, 53

H.Rep. No. 694, reprinted, 1963 U.S. Code, Cong. & Ad. News 1054 37

H.R. No. 94-58 47

H.Rep. No. 95-1188, reprinted, 1978 U.S. Code, Cong. & Ad. News 7312 . . . . . 45, 46, 50, 52

S.Rep. No. 94-160, 94th Cong., 1st Sess. (1975) . 11, 39

1967 U.S. Code, Cong. & Ad. News 2071 . . . . . 38, 42

1978 U.S. Code, Cong. & Ad. News 7415 36

Senate J., 1st Sess., 150 (1789) 37

121 Cong. Rec.:
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125 Cong. Rec. H3637 22

126 Cong. Rec. S1826 22

126 Cong. Rec. H3497 22

Pennsylvania Statutes, Regulations and Legislative History:
Mental Health and Mental Retardation Act of 1966,
50 Pa.C.S.A. §§4101, *et seq.*: 27, 2A
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1 Pa.C.S.A. §1921	27
Act 424, Laws of Pennsylvania (May 15, 1903)	2A
Act 42, Laws of Pennsylvania (April 4, 1907)	2A
Act of June 12, 1913, 32 Laws of Pennsylvania 494	2A
6 Pa. Bull. 2883 (Nov. 13, 1976)	9, 32
1966 Pa. Legis. J., 3d Spec. Sess., No. 33 (Sept. 27, 1966)	27
All States' Habilitation Statutes	70
Other Authorities:	
Adams, Mental Retardation and Its Social Dimensions (1971)	3
Blatt, Exodus From Pandemonium: Human Abuse and a Reformation of Public Policy (1970)	4
Comptroller General, Report to the Congress, Returning the Mentally Disabled to the Community: Government Needs to Do More (1977)	46
Goebel, History of the Supreme Court of the United States: Antecedents and Beginnings to 1801 (1971)	37
Haskell, Mental Deficiency Over a Hundred Years, 100 Am. J. Psychia. 107 (1944)	3
Heal, et al., Research on Community Residential Alternatives for the Mentally Retarded, in 9 International Review of Research on Mental Retardation (Ellis ed. 1978)	5
Henig, Maxims, in Branch's Principia Legis et Aetquitatis	68

TABLE OF AUTHORITIES — *(Continued)*

Other Authorities: **Page**

HEW, Special Report: Mental Retardation, Hearings before the Subcommittee on Departments of Labor, HEW, and Related Agencies of the House Committee on Appropriations, 96th Cong., 2d Sess., Part 2 46

The History of Mental Retardation (Rosen, Clark & Kivitz eds. 1976) 3

Howe, Final Report of the Superintendent to the Trustees of the Massachusetts School for Idiotic Children (1874), quoted in President's Committee on Mental Retardation, Mental Retardation: Past and Present (1977) 2

Kanner, A History of the Care and Study of the Mentally Retarded (1964) 3

Masters and Magistrates in the Federal Courts, 88 Harv. L. Rev. 779 (1975) 64

President's Panel on Mental Retardation, Report of the Task Force on Law (1963) 37

Seguin, The Moral Treatment, Hygiene and Education of Idiots and Other Backward Children . 3

Sloan, Four Score and Seven, 68 Am. J. Ment. Defic. 6 (1963) 3

Special Project, The Remedial Process in Institutional Reform Litigation, 78 Colum. L. Rev. 784 (1978) 60, 64

Thorpe, Constitutions and Charters 36

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Wolfensberger, "The Definition of Normalization: Update, Problems, Disagreements and Misunderstandings," in Normalization, Social Integration and Community Alternatives (Flynn & Nitsch eds. 1980) 4A

Wolfensberger, The Origin and Nature of Our Institutional Models, in President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded (Kugel & Wolfensberger eds. 1969) 3

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79-1414, 79-1415 and 79-1489

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1979

PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
Petitioners

v.

TERRI LEE HALDERMAN, *et al.*,
PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS,
et al.,
and
UNITED STATES OF AMERICA,
Respondents

On Petitions for Writs of Certiorari
to the United States Court of Appeals
for the Third Circuit

BRIEF FOR RESPONDENTS
TERRI LEE HALDERMAN, *et al.*

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Third Circuit, dated December 13, 1979, is reported at 612 F.2d 84 (3d Cir. 1979) and appears at 89a

et seq. The opinion of the District Court, dated December 23, 1977, is reported at 446 F.Supp. 1295 (E.D. Pa. 1977), and appears at 6a *et seq.* The District Court's opinion and judgment of March 17, 1978, reported at 446 F.Supp. 1295 (E.D. Pa. 1978), appears at 76a *et seq.*

STATEMENT OF THE CASE

"Now the danger of misdirection in this pious and benevolent work is, that two false principles may be incorporated with the projected institutions which will be as rotten piles in the foundations and make the future establishments deplorably defective and mischievous. These are, first, close congregation; and, second, the life-long association of a large number of idiots; whereas, the true, sound principles are: separation of idiots from each other; and then diffusion among the normal population . . . For these and other reasons it is unwise to organize establishments for teaching and training idiotic children, upon such principles as will tend to make them become asylums for life . . . *Even idiots have rights* which should be carefully considered![1]"

With these cautionary words, Dr. Samuel Gridley Howe, founder of the first public facility for the retarded in the United States, prescribed in 1874 how, and how not, to provide the education and training which retarded people require.

Dr. Howe's admonition was not heeded. The small, short-term community schools created in the mid-nine-

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1. Howe, *Final Report of the Superintendent to the Trustees of the Massachusetts School for Idiotic Children* (1874), quoted in President's Committee on Mental Retardation, *Mental Retardation: Past and Present* 5 (1977) (emphasis in original).

teenth century have become massive isolated institutions in the late twentieth century in which retarded people endure grotesque lives forced upon them by lack of alternatives.[2] Although death, injury, violence, physical and psychological abuse are familiar to all who know institutions, their destructive consequences are rivalled by those of the pervasive degradation, hopelessness and

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2. In 1838, the first school for the retarded was established in the Saltpetriere mental hospital outside Paris and in 1842 a portion of the Bicetre mental hospital was set aside for such training. A facility for the retarded was founded in 1842 in Berlin, in 1846 in Leipzig, and in the same year in Bath, England. In January, 1846, Judge Horatio Byington offered a resolution to the Massachusetts legislature calling for a commission to investigate the status of the retarded in the state; the commisison's 1848 report was followed by the opening of an experimental school in South Boston in October, 1848, headed by Dr. Howe. A private school for the retarded had opened in Barre, Massachusetts, just three months before Howe's. These first facilities were quickly followed by schools for the retarded in New York in 1851, Pennsylvania in 1852, and Ohio in 1857. The early schools had provided intensive training for short periods of time and had great success in returning retarded people to life in their communities. By 1888, about 4,000 people lived in the fourteen state and private institutions for the retarded in the United States. These developments are reported in detail in 1 *The History of Mental Retardation* (Rosen, Clark & Kivitz, eds., 1976).

For the evolution of institutionalization of the retarded, see Testimony of Dr. Philip Roos, Tr. 1-94 to 95 (citations to transcript volume number and pages); District Court opinion at 446 F.Supp. at 1299-1300; 10a-13a (citations to opinions below are to the Petitioners' Joint Appendix filed with their petitions for certiorari); Adams, *Mental Retardation and Its Social Dimensions* 16-51 (1971), Wolfensberger, *The Origin and Nature of Our Institutional Models*, in President's Committee on Mental Retardation, *Changing Patterns in Residential Services for the Mentally Retarded* (Kugel and Wolfensberger eds. 1969), Kanner, *A History of the Care and Study of the Mentally Retarded* (1964); Sloan, *Four Score and Seven*, 68 Am. J. Ment. Defic. 6 (1963); Haskell, *Mental Deficiency over a Hundred Years*, 100 Am. J. Psych. 107 (1944); Seguin, *The Moral Treatment, Hygiene, and Education of Idiots and Other Backward Children* (1846).

helplessness which comes of denial of individual attention, training and care.[3]

In recent decades, every element in American society touched by the retarded has reponded with increasingly determined action to halt this decimation. Congress, state legislatures, federal and state courts, executive officials, and other citizens have adopted unequivocal mandates both to protect the rights of people in institutions and to ensure provision of individualized community services to those who need them, avoiding the ghastly spectre of retarded people being dumped from inadequate institutions into stark isolation outside them.

For the retarded, life outside the large congregate custodial institution emphatically does not mean life in a monolithic single-choice system called "the community." This common "either-or" misconception fails to appreciate the stunning variety of residential and sup-

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3. 446 F.Supp. at 1302-1311; 18a-40a; 612 F.2d at 92-94; 103a-108a. One experienced commentator has described "the feeling of hopelessness and helplessness that permeates the minds and souls of those in our institutions and those others of us who visit there. For the ordinary condition in our institutions is not one involving violence or brutality or illegal treatment — although these are much more ordinary in institutions than they are in the community. The ordinary condition is boredom more than brutality, legal abuse more than illegal assault, and a subtle degradation rather than a blatant holocaust. However, this genteel catastrophe is deadening, it's overwhelming, for it floods out whatever opportunities residents and staff have to rise together in some common attempt for personal dignity and mutual human concern. This subtle catastrophe is the mortar filling in the cracks and anchoring the devastation and permanence manufactured by the heavy hand of the System." B. Blatt, *Exodus from Pandemonium: Human Abuse and a Reformation of Public Policy* 79-80 (1970).

portive services available to and now serving retarded citizens.[4]

Petitioners insist that the issue before this Court is one of statutory interpretation. Did the Pennsylvania legislature (and state courts of state-wide jurisdiction) and the United States Congress, all acting with full knowledge of the facts — in essence, the facts unchallenged here — mean what they said when they declared explicit "rights" for retarded people to habilitation, individually determined and provided in an appropriate environment? While the answer to this question is affirmative, as the statute's plain words and history shows, the undisputed facts and procedural history must be examined for their dispositive effect on both the liability and relief determinations by the courts below.

This case presents no issue regarding the wisdom or propriety of avoiding unnecessary institutionalization of

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4. Among these services are "diagnosis, evaluation, treatment, personal care, day care, domiciliary care, special living arrangements, training, education, sheltered employment, recreation, counseling of the individual with such disability and of his family, protective and other social and socio-legal services, information and referral services, follow-along services and transportation services necessary to assure delivery of services to persons with developmental disabilities." 42 U.S.C. §6001(8)(A). "The term 'alternate community living arrangement services' means such services as will assist persons with developmental disabilities in maintaining suitable residential arrangements in the community, and includes in-house services (such as personal aides and attendants and other domestic assistance and supportive services), family support services, foster care services, group living services, respite care, and staff training, placement, and maintenance services. *Id.* at §6001(8)(E). Other services are defined at §§6001 (8)(B), (C), (D) and (F). As of 1971, Pennsylvania had identified at least ten different models of community services. Tr. 7-85 Dybwad; PARC Ex. 24; Ex. P-16; *see* Ex. G-48 at photographs 69-82. For a taxonomy of residential facilities in the community, *see* Table 2 in Heal, *et al.*, *Research on Community Residential Alternatives for the Mentally Retarded*, in 9 International Review of Research on Mental Retardation (Ellis ed. 1978). *See* Tr. 5-141 to 161 Girardeau (describing range of services available in Pennsylvania).

people who are retarded.[5] This case presents no issue regarding the brutal and abominable conditions to which plaintiffs were subjected at the Pennhurst State School and Hospital nor does it present any questions regarding *facts* concerning the ability of all retarded people to learn and grow, their need to do so in an appropriate environment through individual habilitation plans, and, finally, the disutility of institutions in providing benefits to retarded people.[6]

In addition, this case presents no question regarding the limits imposed on the states by the Constitution when they confine retarded persons, for whatever reason in whatever environment.[7]

A narrative summary of the record in this case is attached as an Appendix to this brief.

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5. In his opening statement, Deputy Attorney General Norman Watkins stated, "The Commonwealth quite simply is not defending Pennhurst." Tr. 1-26. The institution had itself been slated for elimination by Pennsylvania with the intention of placing virtually all of its residents into community facilities. Tr. 28-45 to 50 Rice, with defendant officials and their retained experts determining that every Pennhurst resident could be served in a variety of community settings. 446 F.Supp. at 1312, 1313, 1325; 43a, 47-48a; 78a; 612 F.2d at 116; 160a; citations to record at notes 194 to 196 *infra*.

6. The defendants do not challenge any factual findings on appeal as clearly erroneous. *See* F.R.Civ.Pro. 52(a); *United States v. United States Gypsum Co.*, 333 U.S. 364, 394-395 (1948); *Graver Tank & Mfg. Co. v. Linde Air Products Co.*, 336 U.S. 271, 274-275 (1949) (application to facts based on expert testimony); cases cited at Argument I.E. *infra*.

7. Constitutional questions considered by the District Court were not decided by the Court of Appeals or raised in this Court. *See Aetna Casualty Co. v. Flowers*, 330 U.S. 464 (1947); *Alaska v. American Can Co.*, 358 U.S. 224 (1959); *Hess v. United States*, 361 U.S. 314 (1960).

SUMMARY OF ARGUMENT

1. Although the nineteenth century founders of the first facilities for the retarded — small short-term community schools — warned against the possibility, those community schools became the large long-term ineffective institutions of the late twentieth century in which physical and psychological abuse are as common as chronic denial of individual attention, training and care. In recent decades, Congress, state legislatures, courts, executive officials and other citizens have acted both to protect the rights of people in institutions and to ensure provision of individualized community services to those who need them, avoiding the spectre of retarded people being dumped from inadequate institutions into unstructured isolation outside them.

2. For the retarded, life outside the custodial institution emphatically does not mean life in a monolithic single-choice system called "the community." This common "either-or" misconception, adopted in petitioners' argument, fails to appreciate the stunning variety of residential and supportive services available to and now serving citizens in "institutions" quite different from those condemned by Congress and the Pennsylvania legislature.

3. Certiorari should be dismissed as improvidently granted because of changes in the law, proposed regulatory changes, recent decisions of the Court, state law and the factual nature of this case.

a. The Department of Health and Human Services recently proposed changes in developmental disabilities program regulations which significantly strengthen the rights recognized in 42 U.S.C. §6010. *See Murel v. Baltimore City Criminal Court*, 407 U.S. 355, 358 (1972).

b. Congress has enacted the Civil Rights of Institutionalized Persons Act, P.L. 96-247, 94 Stat. 349, Section 9 of which expresses the sense of Congress that fed-

eral agencies should ensure use of federal funds for "correction or elimination of such unconstitutional or illegal conditions" as, respondents suggest, are represented by the unnecessary confinement of hundreds of individuals at the Pennhurst institution.

c. Two decisions of the Court after certiorari was granted affect this case. *O'Bannon v. Town Court Nursing Home*,____U.S.____(1980), holding that institutionalized people have no right to remain in a decertified facility even if they would be harmed by a transfer to a new facility, and *Maine v. Thiboutot*,____U.S.____(1980), resolving the question of whether 42 U.S.C. §1983 provides a private remedy for violations of a federal statute.

d. State law supports all aspects of the judgment below, including the right to habilitation in the least restrictive alternative and individual determination of the needs of disabled people.

e. For the parties before the Court in this case, the facts are undisputed. Retarded people can be treated without institutionalization and at less cost. There are funds available in Pennsylvania to implement defendants' own policies. The Pennhurst institution itself was scheduled by the state Department of Public Welfare to be "empty" by 1983. Each member of the Court of Appeals found petitioners' actions with regard to respondents' at Pennhurst to be totally unacceptable. This case boils down to one of a factual nature and it is therefore inappropriate for review on certiorari.

4. Pennsylvania statutory and case law guarantee retarded persons the right to habilitation, individually determined and provided in an appropriate least restrictive setting. State law is an independent and dispositive ground for the judgment of the Court of Appeals.

a. The state statute guarantees "adequate . . . mental retardation services for all persons who need them." Pennsylvania legislative history, which according to state law must be considered if there is any doubt as to

the plain meaning of a statute, demonstrates that, "The object of this legislation is to make it possible for every mentally disabled person to receive the kind of treatment he needs, when and where he needs it."

b. Both the majority and the dissenting opinions in the Court of Appeals recognized, as petitioners are loath to do, that the judgment of that Court rested its least restrictive environment rule on state law in addition to federal law. State law requires that 1) individual needs be fully addressed, 2) non-institutional care be favored, 3) habilitation be provided in community settings where appropriate, 4) there be dramatic institutional improvements. Decisions of state-wide courts, including one of August 1, 1980, and of local courts, have interpreted Pennsylvania law consistently with the mandate of the Court of Appeals.

c. For people presently at Pennhurst, a right to be moved to a less restrictive environment exists under state law. For potential future commitments to Pennhurst, no person may be confined there without a judicial determination that the person's needs cannot be satisfied through development of a community program; this is the case under state regulations adopted after a federal court voided the state commitment statute, 50 Pa. C.S.A. §4406. *Goldy v. Beal*, 429 F.Supp. 640 (M.D. Pa. 1976); 6 Pa. Bull. 2883 (Nov. 13, 1976). Petitioners neglected to bring this case and the ensuing regulations to the Court's attention.

5. Initial Congressional reaction to obsolete custodial facilities providing inappropriate services to the retarded was legislation beginning in 1963 providing financial aid to the states for construction and grants to encourage community services. This approach did not work, Congress found, and after several years of intense study, many hearings and consideration of alternative initiatives, Congress understood that the conditions under which retarded people are confined in most institu-

tions render impossible the fulfillment of the habilitation standard which Congress established as national policy. Therefore, in 1975, Congress departed from the existing laws' sole emphasis on funding and enacted a Bill of Rights explicitly intended to eliminate the inappropriate care to which Congress found a "vast majority of the developmentally disabled" were being subjected. This consummate equal rights initiative, strengthened in 1978, is the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000 *et seq.*, the federal statutory ground on which the Court of Appeals rested its judgment.

a. Two purposes are evident in the title of the statute, to *assist* the developmentally disabled and to provide the beneficiaries of the Act with a *Bill of Rights*. In English and United States history, the phrase "Bill of Rights" has ringing import; it has always been used to refer to the establishment of rights and the plain meaning of the Bill of Rights section of the Act, 42 U.S.C. §6010, admits of no other interpretation. Section 6010 codifies "a right to appropriate treatment, services and habilitation," §6010(1), "designed to maximize the developmental potential of the person," and "provided in the setting that is least restrictive." §6010(2).

b. Every finding of the lower courts in this case is matched by a congruent prior finding of the Congress:

> 1) Mental retardation is an educational handicap, not a disease; retarded people are not subhuman, objects of pity, eugenic misfits or eternal children.
>
> 2) Misconceptions and myths have resulted in segregation, sterilization, stigmatization and institutionalization of retarded people.
>
> 3) Congress adopted the developmental model of services to retarded people, finding that, with proper habilitation, every retarded person is capable of growth toward the goal of self-sufficiency; therefore custodial care "must be rejected."

4) Despite a decade of federal funding for institutions, deplorable conditions and scandals prompting successful litigation continued to plague such facilities; dramatic changes were required to benefit the inmates of institutions.

5) Persons forced to vegetate on wards of institutions become further physically and mentally handicapped.

6) State officials conceded that inhumane and non-habilitative conditions continue to exist in institutions for the retarded.

7) Institutions generally do not provide habilitation.

8) Institutions are dangerous.

9) "Most of the institutions themselves are anachronisms, and . . . rapid steps should be taken to phase them out." S.Rep. 94-160 at 32-33.

10) Reducing institutional population is not sufficient; creation of community services, structured and individually determined, is the necessary remedy.

11) The "vast majority of persons now institutionalized should not be in these institutions at all." S.Rep. 94-160 at 33.

12) Normalization is integral to habilitation for retarded people and it must occur, by definition, in the least restrictive environment appropriate to the individual's needs.

13) Aware of the unnecessary expense of institutions, particularly where no habilitation is provided, Congress determined that the states must develop expanded community services; Congress expected that the use of billions of dollars from various federal programs for the disabled would free more dollars for community care. The Bill of Rights Act was intended to lever already available federal and state funds for the benefit of the disabled.

c. The hearings, debates, committee reports and the structure of the Bill of Rights Act demonstrate that Congress intended in §6010 to codify those civil rights recognized by the courts.

6. Developmentally disabled people may assert their rights, and federal courts may provide a remedy, under either 42 U.S.C. §1983 or an implied private right of action. Both these alternatives are available to effectuate the Congressional intention that people such as those confined at Pennhurst have their day in court.

a. 42 U.S.C. §1983 provides a remedy for official deprivation of federal statutory rights. *Maine v. Thiboutot*, ____ U.S. ____ (1980). The Bill of Rights Act establishes substantive rights to individualized habilitative services and to an appropriate habilitative environment. The power of Congress to establish such rights is not disputed by petitioners, although they deny Congress' intention to do so. That power, however, is clear and stems from two alternative sources.

1) Legislation enacted pursuant to Section 5 of the Fourteenth Amendment may impose severe restraints on state action and discretion, with the Court giving great deference to Congressional findings that particular steps are "appropriate" exercises of legislative authority. *Regents of University of California v. Bakke*, 438 U.S. 265, 302 n.41 (1979) (collecting cases); *McCulloch v. Maryland*, 17 U.S. 316, 421 (1819). Congress, prompted by the conditions of the disabled and judicial recognition of their constitutional rights, recorded its intention that the Bill of Rights Act enforce the Fourteenth Amendment. Rights violated at Pennhurst and encompassed in the Act include those to receive more than zero education, *Rodriguez v. San Antonio School District*, 411 U.S. 1 (1973), personal security, *Ingraham v. Wright*, 430 U.S. 651, 673 (1977), institutionalization the nature and duration of

which bear a reasonable relation to its purpose, *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), freedom from custodial care for non-dangerous persons capable of living safely with assistance outside the institution, *O'Connor v. Donaldson*, 422 U.S. 567, 576 (1975), and freedom from training and education in separate stigmatizing and unequal facilities, *Brown v. Board of Education*, 356 U.S. 148 (1954).

2) Having accepted federal funds under the Bill of Rights Act for its unified state-county retardation program, Pennsylvania must comply with the requirements imposed by Congress under its spending clause powers. *Helvering v. Davis*, 301 U.S. 619 (1937); *Rosado v. Wyman*, 397 U.S. 397 (1970); *Miller v. Youakim*, 440 U.S. 125 (1979).

b. Petitioners grasp at straws when they inject a question on which certiorari was not granted: whether the Bill of Rights Act can be enforced exclusively by a federal funding cut-off by the Secretary of Health and Human Services on her own or under a court order. The "power to cut off federal funds for noncompliance with statutory requirements," a power resting with federal departments under every federal-state cooperative program, has repeatedly been "considered and rejected" by the Court as a basis upon which to deny judicial power to review state action as to individuals. *Rosado v. Wyman*, 397 U.S. 397, 420 (1970); *Cannon v. University of Chicago*, 441 U.S. 677 (1979). There is no word or phrase in the Bill of Rights Act or its legislative history even hinting at an intention to lodge exclusive enforcement in a funding cut-off remedy. To the contrary, Congress specifically intended the Bill of Rights Act to support and encourage legal action by disabled people themselves and, further, Congress established a system to protect and advocate the rights of disabled people through pursuit of legal remedies. The Secretary's authority to cut off program funds can be exercised only in

the extreme circumstance where an entire program fails; that authority is an insufficiently delicate instrument to vindicate particular individuals' personal rights. And it is personal rights which are the concern of §§6010(1) and (2).

c. An independent though consistent alternative to §1983 which provides a judicial remedy for respondents is their implied private right of action under the Bill of Rights Act itself. The question is "one of statutory construction" and the Court's "task is limited solely to determining whether Congress intended to create the private right of action asserted. . . ." *Touche Ross & Co. v. Redington*, 442 U.S. 560, 568 (1979). Cases finding implied private remedies set forth indicia for taking the measure of statutes. A private remedy is implied where "the statute in question at least prohibited certain conduct or created federal rights in private parties," *Touche Ross & Co., supra*, 442 U.S. at 569; *Cannon, supra*, 441 U.S. at 690 n. 13, where it "make[s] effective the congressional purpose," *J.I. Case v. Borak*, 377 U.S. 426, 433 (1964), where the right intended by Congress will thereby be enforced, *Allen v. State Board of Elections*, 393 U.S. 544 (1969), and, finally, a remedy is implied "for the enforcement of civil rights, even when Congress has spoken in purely declarative terms." *Cannon, supra*, 441 U.S. at 690 n. 13. The Bill of Rights passes muster under these criteria; it is a civil rights statute enacted to benefit a particular class and a private action will generate enforcement in accordance with the policies and expectations of Congress.

1) *Cort v. Ash*, 422 U.S. 66, 78 (1975), provides the familiar template for analysis of this question and each of the four *Cort* factors are satisfied. Plaintiffs below are the undisputed "especial beneficiaries" of the Bill of Rights Act and Congress fully intended that the right to habilitation "should be protected and assured by Congress and the courts." H. Conf. Rep. 94-473 at 42. Con-

gress was aware and approved of institutional disability litigation and expected "substantial legal and advocacy pressure," 121 Cong. Rec. 16516 (Sen. Williams) and "challenges in the courts, for the kinds of rights which are being guaranteed in this legislation. That is the way it is done." 124 Cong. Rec. S15662-15663 (Sen. Kennedy).

2) The last two *Cort* factors are satisfied in that a private remedy is not inconsistent with the underlying purpose of the legislation which is to secure for *individuals* that habilitation which adequately serves their needs. The purpose is both to avoid the use of funds for illegal and unconstitutional purposes and to protect individuals against the effects of such practices. *Cannon, supra*, 441 U.S. at 703-704. Also, the cause of action is not one traditionally relegated to state law. Congress was aware that actions to secure services to retarded people to meet their habilitative needs have been brought in federal courts for many years under the Constitution and federal statutes. The particular §6010 cause of action has no counterpart in state law and cannot be said to be "traditionally relegated" to the states; there is and can be no reason to forbid federal courts to act upon the separate federal interests which Congress articulated in the Bill of Rights Act. Legitimate state concerns are not impaired by an implied remedy. Persons claiming an official denial of habilitation must show a casual connection between the injury and the allegedly wrongful conduct. *Rizzo v. Goode*, 423 U.S. 362 (1976). State officials are entitled to a qualified immunity for actions undertaken in good faith. *O'Connor v. Donaldson*, 422 U.S. 563 (1975). Persons actually injured by denial of care, however, will be entitled to injunctive relief ensuring future habilitation. *See Edelman v. Jordan*, 415 U.S. 651 (1974).

7. Where government officials adamantly refuse to remedy their violations of people's rights and where pro-

tection of their federal and statutory rights would otherwise be impossible, individual determinations of need and appointment of a special master with circumscribed supervisory duties does not violate principles of federalism and is not an abuse of discretion. With defendants below refusing on three occasions to devise and present their own proposed remedies, the courts below had no choice but to fashion equitable relief based on the "circumstances present and the options available in each instance." *Swann v. Charlotte-Mecklenburg Board of Education*, 402 U.S. 1, 27 n. 10 (1971).

a. Rather than wrest control of the retardation system from petitioners, the Court of Appeals carefully sculpted a minimal planning and supervisory role for master. In addition, the court found "it is only fitting that the Commonwealth be required to undertake a case-by-case investigation into how each person's rights may best be facilitated."

b. Once liability has been determined, lower courts have broad discretion in the sensitive and delicate task of fashioning relief and the Court "will not direct a recasting of the decree except upon a showing of abuse of discretion." *United States v. Crescent Amusement Co.*, 323 U.S. 173, 185 (1944); *Hills v. Gautreaux*, 425 U.S. 284, 306 (1976); *Milliken v. Bradley*, 433 U.S. 267, 280 n. 15, 281 (1977). Where Congress has by statute declared a national policy or where the public interest may be furthered, the Court's rule has been the relief ought to accommodate those circumstances. *E.g., Virginian Ry. v. Federation*, 300 U.S. 515, 552 (1937).

c. The individual determination remedy is one well within the lower court's discretion. Careful review of the needs and condition of every resident of Pennhurst is a *sine qua non* for determining whether an improved Pennhurst or one of the variety of habilitative alternatives satisfy state and federal law. The nature of the violation of respondents' rights consists of the failure to pro-

vide individually determined habilitation. It is patently frivolous to suggest, as petitioners do, that the question of whether a person is receiving habilitation sufficient to justify confinement at Pennhurst is nonjusticiable. *O'Connor v. Donaldson*, 422 U.S. 563, 574 n. 10 (1975) ("plainly unacceptable to suggest that the courts are powerless to determine whether" "Donaldson was receiving treatment sufficient to justify his confinement"). *See Parham v. J.R.*, 442 U.S. 584, 617 (remand for consideration of individual claims). Retardation and techniques for habilitation are not afflicted by the vagaries of the baffling field of psychiatry; determination of a retarded person's habilitative needs is accomplished through individualized methods and procedures, and with goals, set forth with specificity by Congress. The lower courts did not presume to prescribe habilitation for individuals but left that task in the first instance to professionals acting under professional standards.

d. Petitioners' refusal to suggest any plan of their own devising to remedy the systemic and deplorable violations of respondents' rights compelled the District Court to appoint a special master to develop and supervise enforcement mechanisms. As the court found, implementation would otherwise have been "impossible." The master in no way supplants state and local authorities; the defendants participate in the structuring of relief and, in fact, remain free to offer "a plan that promises realistically to work." *Green v. County School Board*, 391 U.S. 430, 439 (1968). Barring such a plan, a federal court must exercise its broad and flexible power to effectuate a remedial, non-punitive decree. *Milliken v. Bradley*, 433 U.S. 267, 288 (1977). The record below demonstrates what the courts below found as facts, *i.e.*, the failure and refusal of the state and county petitioners to provide services mandated by law and their continued recalcitrance after their liability was determined. "Judicial authority enters only where local authority defaults."

Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. 1, 15 (1971). A more persuasive case of local default can hardly be imagined.

e. Undisputed facts have proven "abominable" conditions in an institution for the retarded condemned by the dissenting judges as "one of the worst institutions of its kind in the world." Every person at Pennhurst, an institution slated by Pennsylvania to be "empty" by 1983, can and should be care for in a continuum of less costly more effective structured community settings. In its equitable discretion, and under the Bill of Rights Act, the District Court properly prohibited further admissions to the institution (Pennhurst policies and state commitment laws already precluded admissions) and required that the antiquated facility be replaced through the development of individually appropriate services. Pennhurst is one of the class of institutions which Congress intended be "phased out." The Court of Appeals ignored these critical facts, acted on hypothetical situations not supported by facts in the record, and erred in modifying these portions of the District Court's order.

8. Declaration of a federal and state statutory right to habilitation threatens neither the policies nor the practices of the states.

a. Relief in this case is tailored to the specific local circumstances of highly developed community services, availability of unspent local funds for Pennhurst dispersal, and years of unjustifiable deprivation of respondents' rights. No mold of universal applicability has been or should be cast by any court because "there is obviously no one plan that will do the job in every case. The matter must be assessed in light of the circumstances present and the options available in each instance." *Swann*, *supra*, 402 U.S. at 27 n. 10, quoting *Green v. County School Board*, 391 U.S. 430, 439 (1968).

b. Every one of the fifty states has, by statute, established some or all of the rights and policies recognized by the lower courts in the case at bar. 26 states establish a right to habilitation or treatment, 17 establish a state responsibility or policy or provide habilitation or treatment, 8 explicitly require an individualized plan and 5 either specify facilities to provide habilitation or treatment or grant authority to enforce laws relating to habilitation or treatment in community centers; some states, of course, fall into several of these categories. *See* Table *infra*, listing states by category. An increasing number of states have responded to federal developments by enacting laws designated to guarantee rights to developmentally disabled people and ensuring small-scale community services to people no matter how severe their disability may be.

c. States' legitimate interests in adopting and pursuing their own strategies for compliance with the Bill of Rights Act are supported, not undermined, by the decisions of the courts below in this case. States would not be required to immediately deinstitutionalize without regard to the context within which each operates. The lower courts' "programs were not, and as a practical matter could not be, intended to wipe the slate clean by one bold stroke . . . " *Milliken v. Bradley*, 433 U.S. 267, 290 n. 22 (1977). Nor did Congress mandate the impossible. A state's effective action to provide individually appropriate habilitation under §6010 cannot be completed in a day, but it can be undertaken.

ARGUMENT

I. Certiorari should be dismissed as improvidently granted because of changes and proposed changes in the law, recent decisions of this Court, the dispositive effect of state law and the factual nature of this case.

Changes in the law, proposed regulatory changes, state law, recent decisions of this Court, and the factual nature of the case, singly and in combination, strongly indicate that certiorari has been improvidently granted.

A. Developmental Disabilities Program — Proposed Regulations

Among the issues before the Court is the interpretation of Section 111 of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6010. The Department of Health and Human Services recently published proposed regulations defining and significantly strengthening the rights recognized in the statute. 45 Fed. Reg. 31006, 31014 at §1385.2 and §1385.3 (c).

These regulations for the first time define "Institution" as "any residential facility in which a person with a developmental disability is housed with non-related persons." §1385.2. This makes it clear that references to programs in "institutions" or standards for "institutions," *e.g.*, §6010(3), refer to small community facilities and not simply large isolated custodial facilities.

In addition, the regulations state:

> The treatment, services, and habilitation for persons with developmental disabilities *shall* be designed to maximize the developmental potential of the person and *shall* be provided in the setting that is least restrictive of the person's personal liberty.

§1385.3(c)(2) (emphasis supplied). In the statute, §6010(2), each "*shall*" above is "should;" the language is otherwise the same.

Where legal requirements in this disability law area are in the process of relevant important change, dismissal of certiorari is appropriate. *Murel v. Baltimore City Criminal Court*, 407 U.S. 355, 358 (1972) (challenge to state mental commitment law):

> We are informed that the statutes governing civil commitment are presently undergoing substantial revision, designed to provide greater substantive and procedural safeguards to committed persons. Accordingly, it seems a particularly inopportune time for this Court to consider a comprehensive challenge to Defective Delinquency Law.

B. Enactment of P.L. 96-247, Civil Rights of Institutionalized Persons Act, 94 Stat. 349

The Civil Rights of Institutionalized Persons Act, P.L. 96-247, was approved May 23, 1980. Although the law is predominantly concerned with procedures for intervention by the United States in institutional litigation, one section has bearing in this case:

> Sec. 9. PRIORITIES FOR USE OF FUNDS.
> (a) It is the intent of Congress that deplorable conditions in institutions covered by this Act amounting to deprivations of rights protected by the Constitution or laws of the United States be corrected, not only by litigation as contemplated in this Act, but also by the voluntary good faith efforts of agencies of Federal, State, and local governments. It is the further intention of Congress that where Federal funds are available for use in improving such institutions, priority should be given to the correction or elimination of such unconstitutional or illegal conditions which may exist. It is not the intent of this provision

to require the redirection of funds from one program to another or from one State to another.

The *Pennhurst* litigation was before Congress in its consideration of this Act.[8] As Representative Kastenmeir, reporting the Conference Report, explained, Section 9 is a " 'sense of Congress' resolution that priority should be given to correcting unconstitutional conditions first." 126 Cong. Rec. H3497 (May 12, 1980).

In view of the "deplorable conditions" which all concede exist at Pennhurst, and the fact that Pennhurst received "extensive funding under the Federal Medicaid statute — more than $6 million of the $27 million" budget in 1975-1976 (Rice, Tr. 26-14), Brief for Petitioners at 26 n. 43, dismissal of certiorari would be appropriate to permit federal agencies to comply with Section 9's intent to ensure use of federal funds for "correction or elimination of such unconstitutional or illegal conditions," Sec. 9, P.L. 96-247, to which respondents are subjected.

C. Recent Decisions of this Court Resolve Several Important Issues in this Case.

After certiorari was granted, this Court decided *O'Bannon v. Town Court Nursing Home*, ____ U.S. ____ (1980), which, in part, held that institutionalized nursing home residents do not have a right to remain in a decertified facility, even if they would be harmed by a transfer to a new residence. In *Halderman*, the institution was condemned by every member of the Court of Appeals which required an individual determination of the need for improved institutional care or one of a variety of non-institutional alternatives. The rationale of *O'Bannon* supports the holding in *Halderman*.

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8. *E.g.*, 125 Cong. Rec. H3637 (May 23, 1979) (Comments of Rep. Railshack); 126 Con. Rec. S1826 (Feb. 27, 1980) (Comments of Sen. Thurmond).

This Court's June 9, 1980 Order added a question to be addressed: "Does 42 U.S.C. §1983 provide a private remedy to enforce the provisions of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000 *et seq.*?" This question was dispositively considered in *Maine v. Thiboutot*, ____ U.S. ____, 48 U.S.L.W. 4859 (June 25, 1980). *See Hagans v. Levine*, 415 U.S. 528 (1974).

D. State Law Fully Supports All Aspects of the Judgment Below.

Pennsylvania law provides a firm foundation for all aspects of the judgment here on review. Fully discussed below in Section II of the Argument, state statutes, judicial decisions and regulations guarantee plaintiffs an enforceable right to individualized habilitation services in the least restrictive appropriate setting.

This Court has not and should not engage in unnecessary federal statutory interpretation when a sufficient non-federal ground for decision exists. *See* notes 9-13, *infra*.

E. The Dispositive Facts are Undisputed and the Issues are Factual in Nature.

"Concurrent findings of fact by two courts below" are entitled to a presumption of correctness. *Memphis Light, Gas and Water Div. v. Craft*, 436 U.S. 1, 16 (1978), quoting *Graver Mfg. Co. v. Linde Co.*, 336 U.S. 271 (1949); *Columbus Board of Education v. Penick*, 443 U.S. 449, 464 (1979); *United Shoe Machinery Corp. v. United States*, 258 U.S. 451, 455 (1922).

While this case presents important abstract legal questions, its essence is factual. Each member of the Court of Appeals found defendants' treatment of plaintiffs totally unacceptable. All parties agree that retarded people can more effectively be treated without

institutionalization and at less cost. There are funds available in Pennsylvania to implement defendants' own policies, and those policies were accepted by the courts below.

Circumstances in other states may be different but, for the parties before the Court on these undisputed facts, the case is one inappropriate for review on certiorari. *See, e.g., Rudolph v. United States,* 370 U.S. 269 (1962).

II. The District Court and the Court of Appeals *en banc* reasonably interpreted dispositive Pennsylvania statutory and case law providing an enforceable right to habilitation, provided in an individually determined least restrictive setting, thereby rendering unnecessary any further decision by the Court.

Pennsylvania statutory and case law guarantee retarded persons the right to habilitation, individually determined and provided in an appropriate least restrictive setting. As the Court of Appeals held, state law is an independent and dispositive ground for its judgment. The rights recognized below are state law rights.

The following discussion explains why this Court should not and need not venture on an excursion into Pennsylvania state law, describes the Court of Appeals decision as to liability and relief under state law, and, finally, summarizes the manner in which state law provisions explicitly require affirmance of the judgment below.

A. Where the District Court and the Court of Appeals en banc Reasonably Interpreted Pennsylvania Statutory and Case Law, Any Further Decision by this Court is Unnecessary.

Regardless of this Court's own view of particular state law interpretations by the lower federal courts, such interpretations are upheld under the Court's long-

established practices of avoiding involvement in local law disputes and deferring to determinations by the district courts and courts of apppeal:

> In comparable circumstances, this Court has accepted the interpretation of state law in which the District Court and the Court of Appeals have concurred even if an examination of the state-law issue without such guidance might have justified a different conclusion.

Bishop v. Wood, 426 U.S. 341, 346 (1976) (note 10, collecting cases, omitted), *Cort v. Ash*, 422 U.S. 66, 73 n.6 (1975) ("indeed, our practice of deference to such determinations should generally render unnecessary review of their decisions in this respect.") Sitting in their respective states and "familiar with the intricacies and trends of local law, *Hillsborough v. Cromwell*, 326 U.S. 620, 630 (1930), the view of the lower courts are accorded the greatest deference in this Court[9] and are not

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9. *Henderson Co. v. Thompson*, 300 U.S. 258, 266 (1937); *Reitz v. Mealey*, 314 U.S. 33, 39 (1941); *MacGregor v. State Mutual Life Assurance Co.*, 315 U.S. 280, 281 (1942); *Steele v. General Mills*, 329 U.S. 433 (1947); *Gardner v. New Jersey*, 329 U.S. 701 (1949); *Propper v. Clark*, 337 U.S. 472, 486-489 (1949); *Ragan v. Merchants Transfer and Warehouse Co.*, 337 U.S. 530 (1949); *Skelly Oil Co. v. Phillips Petroleum Co.*, 339 U.S. 667, 674 (1950) ("This contention was rejected below, and we do not reexamine local law as applied by the lower courts."); *Williams v. United States*, 341 U.S. 97, 100 (1951); *Bernhardt v. Polygraphic Co.*, 350 U.S. 198, 204 (1956); *General Box Co. v. United States*, 351 U.S. 159, 165 (1956); *The Tungus v. Skovgaard*, 358 U.S. 588 (1959); *United New York and New Jersey Sandy Hook Pilots Assoc. v. Halecki*, 358 U.S. 613 (1959); *Sims v. United States*, 359 U.S. 108 (1959); *County of Allegheny v. Mashuda Co.*, 360 U.S. 185 (1959); *United States v. Durham Lumber Co.*, 363 U.S. 522 (1960); *Richards v. United States*, 369 U.S. 1 (1962); *Appalachia Power Co. v. American Institute of Certified Public Accountants*, 80 S.Ct. 16 (1959) (Brennan, J., as Circuit Justice); *Commissioner v. Bosch's Estate*, 387 U.S. 456 (1967); *Estate of Spiegel v. Commissioner*, 355 U.S. 701 (1949).

disturbed absent "a plain showing of error," [10] "a definite conviction of error in the conclusion,"[11] or a decision that the lower court is "clearly wrong."[12]

Petitioners' rejoinder to this unbroken line of authority is that the "state law holding was unnecessary and insufficient to support affirmance. *See Murdock v. City of Memphis*, 87 U.S. 429 (1875)." Brief for Petitioners at 41, n.65. *Murdock*, on jurisdiction over judgments of state courts, has nothing to do with the case. In any event, the necessity and sufficiency of the state law holding is shown in Section C below.

Never in its history has this Court expended its energies to parse the meaning of state law when lower federal courts have provided their views.[13] There is no necessity or reason to depart now from this salutary path.[14]

B. The Court of Appeals and District Court Decisions are Based on Independent Dispositive Determinations of a State Law Right to Habilitation, Individually Determined and Provided in an Appropriate Least Restrictive Setting.

Disregarding explicit language in the opinion below, petitioners assert that the Court of Appeals did not "find a state right to treatment in the least restrictive environment." Brief for Petitioners at 41. On the contrary, the court below firmly and unequivocally established de-

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10. *Palmer v. Hoffman*, 318 U.S. 109, 118 (1943).

11. *Helvering v. Stuart*, 317 U.S. 154, 163 (1942).

12. *The Tungus v. Skovgaard*, 358 U.S. 588 (1959).

13. The Court does not appear to have reviewed a case in which state law was dispositive and then to have reversed the interpretation of state law provided by the lower courts. Cf. *Thompson v. Consolidated Gas Utilities Corp.*, 300 U.S. 55 (1937) (no state issue; constitutional issue reached); *Elkins v. Moreno*, 435 U.S. 647 (1978).

14. Significantly, the petitioners themselves are divided in their presentation of their position. The Pennhurst Parents-Staff Association does not claim that the lower courts incorrectly determined state law. Brief for Petitioners at 40.

fendants' liability for violating state law guarantees and, in addition, mandated specific relief responsive to the state law requirement of appropriate habilitation in the least restrictive setting.[15]

Pennsylvania's Mental Health and Mental Retardation Act of 1966, 50 Pa.C.S.A. §§4101 *et seq.*,[16] creates a unified state and county system intended by the legislature to "provide a continuum of services — out-patient, in-patient, diagnostic treatment, evaluation and research, a procedure of commitment under almost all conceivable types of circumstances."[17] Its prime sponsor, Senator Pechan, stated that the legislation's purpose was to guarantee a right to services in whatever setting is appropriate:

> The object of this legislation is to make it possible for every mentally disabled person to receive the kind of treatment he needs, when and where he needs it. It will make those services available to every citizen in every community which are now available only to a lucky few, in the more progressive communities.[18]

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15. The dissenting judges, unlike the petitioners here, recognized that the "majority seems to implicitly rest its least restrictive treatment rule in part on Pennsylvania law." 612 F.2d at 122; 175a.

Assuming a state law right to treatment, the dissent's discussion of state law concentrated on establishing a proposition not disputed here or by the majority in the Court of Appeals: that institutions are not prohibited under state law.

16. Several provisions of this Act were examined and upheld by the Court last term in Secretary, *Department of Public Welfare v. Institutionalized Juveniles*, 442 U.S. 640 (1979).

17. 1966 Pa. Legis. J., 3d Spec. Sess., No. 33, 76 (Sept. 27, 1966). (Sen. Sesler), quoted at 612 F.2d at 101; 123a.

18. *Id.* at 100; 123a (Sen. Pechan). Pennsylvania law *in haec verba* permits study of contemporaneous legislative history and the circumstances prompting the law. 1 Pa.C.S.A. §1921; *Hellertown Mfg. Co. v. Pennsylvania*, 480 Pa. 358, 390 A.2d 732 (1978); *Commonwealth Higher Education Assistance Agency v. Abington Memorial Hospital*, 478 Pa. 514, 387 A.2d 440 (1978). The state law was responsive to the community services federal initiatives, notes 30-32 *infra*.

The statutory mandate fulfills the promise of its enactors. "[A]dequate . . . services for all persons who need them" are guaranteed:

> §4201. General Powers and Duties of the Department.
>
> The department [of public welfare] shall have the power, and its duty shall be:
>
> (1) to assure within the State the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them, regardless of religion, race, color, national origin, settlement, residence, or economic or social status.

50 Pa. C.S.A. §4201.

The Court of Appeals was correct in its conclusion that the state law means what it says; "adequate services" must be provided. 612 F.2d at 100; 122a-123a. The lower court therefore held that "to the extent Pennsylvania maintains facilities for the mentally handicapped, those facilities must provide adequate treatment or habilitation." *Id.* at 102; 127a.[19]

The Court of Appeals held that every right and corresponding item of relief based in the federal statute is also part and parcel of the state statute.

1. *Individual needs must be addressed under state law:*

> The state statute, like the federal statute, was focused on *individual* needs. Since the statutory

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19. Under Pennsylvania law, "facilities" is a broad term including both large isolated institutions and a variety of smaller community programs. " 'Facility' means any mental health establishment, hospital, clinic, institution, center, day care center or other organizational unit, or part thereof, which is devoted primarily to the diagnosis, treatment, care, rehabilitation or detention of mentally disabled persons." 50 Pa.C.S.A. §4102.

> rights to treatment, state and federal, vindicate the individual patient's fundamental interest in personal liberty, it is only fitting that the Commonwealth be required to undertake a case-by-case investigation into how each person's rights may best be facilitated.

612 F.2d at 115; 157a (emphasis in original).

2. *Non-institutional care is favored under state law:*

> However, we have recognized that although institutionalization is strongly disfavored, it is not foreclosed by the governing federal and state statutes. It is conceivable that in processing a given future application, a Base Service Unit will find that no available CLA is suitable for the individual, life in the community is not possible and no other alternative institution in the relevant geographic area is available.

612 F.2d at 115-116; 159a.

3. *Provision of habilitation in community settings can be imposed under state law.*

> The Counties contend, however, that while they may have *some* responsibilities under the Act to provide habilitation to the retarded, those responsibilities are exhaustively specified in section 301(d), and no other duties — such as habilitation at institutions or community living arrangements — can be imposed on them. We reject this suggestion.

612 F.2d at 103; 128a-129a (emphasis in original, footnote omitted).

4. *Dramatic institutional improvements are required under state law.*

> [S]tate and federal laws plainly require that if Pennhurst is to remain open for at least some pa-

> tients, it must be dramatically improved so as to provide adequate habilitation.

612 F.2d at 116; 160a.

C. State Law Requires Affirmance of the Judgment Below

Without exception, decisions of Pennsylvania courts, state and federal, support the statutory analysis of the Pennsylvania mental health and retardation act adopted by the Court of Appeals.

For all plaintiff class members, the case law and state regulations mirror the decision below and, with astonishing clarity, set forth identical rights and remedies:

1. *For people currently in Pennhurst.* The Commonwealth Court of Pennsylvania, a court of state-wide jurisdiction and, in this context, the intermediate appellate court, has adopted the "right to habilitation in the least restrictive alternative" doctrine of the court below and another federal court which also found the right in the statute:

> In *Eubanks v. Clarke*, 434 F.Supp. 1022 (E.D. Pa. 1977). the court held that where a state has facilities for the mentally ill which differ significantly in the amount of restrictions on the rights and liberties of the patients, due process requires that the state place individuals in the least restrictive setting consistent with legitimate safety, care and treatment objectives.***
>
> The only justifiable purpose for commitment of the retarded is habilitation and when the state involuntarily commits retarded persons it must provide "minimally adequate habilitation." *Halderman v. Pennhurst State School*, 446 F.Supp. 1295 (E.D. Pa. 1977).

In re Guzan, 405 A.2d 1036 (Pa. Comwlth. 1979).[20] In decision after decision, the Pennsylvania state courts mandate the provision of appropriate services, in the community if indicated, for retarded persons.[21]

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20. *Guzan* involved a request for a transfer of a retarded person from a facility in the community to a state institution called Western Center. The court approved the transfer and held that, as soon as institutional care was no longer necessary, the person should be discharged. In like manner, the Court of Appeals here has approved only necessary institutional care for the purpose of habilitation. An August 1, 1980, decision of the Superior Court describes "the express policy" of state mental health laws" as "favoring lesser over greater instrusions upon a patient's liberty." *In re: Commitment of Ann S.*, ____ Pa. Super. ____ (August 1, 1980).

21. *See e.g., In re: Joyce Z.*, 123 Pitt L.J. 181 (Allegheny Cty. 1975); *In the Matter of Anthony S.*, N. DP 1521-75-11 J 198159 (May 16, 1977), Philadelphia Cty. Juvenile Court); *In the Interest of Angelo P.*, No. J. 194137 (December 6, 1976, Philadelphia Cty.); *In the Interest of Stephanie Lamb*, No. J-184929 (June 30, 1977, Philadelphia Cty.); *In the Interest of Marie O'Hara*, No. 248 Dec. Term, 1976 (April 7, 1977), Philadelphia Cty.); *In the Interest of Edwin Ward*, Nov. Term, 1977 (February 23, 1978 and March 6, 1979, Philadelphia Cty.); *In the Matter of Benjamin Jefferson*, No. 096177, 083977 (November 28, 1978, Chester County); *In the Interest of Moises Santiago*, No. 41-CS-1978 (Chester County; *In the Interest of Mary Alice S.*, No. 75-11919 (April 13, 1976, Delaware Cty.), *In the Interest of Anthony Hariss*, No. 17034 (April 27, 1976, Delaware Cty.); *In the Interest of Carvella Ebron*, No. J-181877 (March 19, 1979, Philadelphia Cty.); *In re Joseph Schmidt*, No. CC660 (February 13, 1979, Allegheny Cty. Orphans Court); *In the Interest of Kenneth P.*, No. J-204067 (March 6, 1979, Philadelphia Cty.).

The Pennsylvania Commonwealth Court, a statewide court, has recognized that state law requires the availability of adequate retardation facilities. *County of Allegheny v. Commw. Dept. of Public Welfare*, 33 Pa. Commw. Ct. 267, 269, 381 A.2d 1014, 1016 (1978). *See Hoolick v. Retreat State Hospital*, 24 Pa. Commw. Ct. 218, 354 A.2d 609 (1976), *aff'd*, 476 Pa. 317, 382 A.2d 739 (1978). A federal court has found a state statutory right to treatment or release. *Eubanks v. Clarke*, 434 F.Supp. 1022 (E.D. Pa. 1977) (*per* Chief Judge Lord).

2. *For potential future commitments*. Since 1971, and continuing until today, no "voluntary" admissions or commitments to Pennhurst have been permitted by the institution.[22] No involuntary commitment to Pennhurst occurs without a judicial determination that the person's needs cannot be satisfied through development of a community program. State regulations adopted in the wake of a federal court order so require.[23]

No basis for reversal of the judgment on state law grounds has been submitted by petitioners; their three bold arguments collapse upon review:

> 1. It is argued that "the responsibility to provide services is limited, as it must be, by the availability of appropriate funds." Brief for Petitioners at 40. The Court of Appeals, of course, recognized this "apparent truism," and noted state law procedures for reallocating costs of services "in the event sufficient funds have not been appropriated." 612 F.2d at 102; 126a. 50 Pa.C.S.A. §§508 and 509 (5). This extraordinary procedure's application would recognize, as did the court below, that "no right is without some limitations." 612 F.2d at 102; 127a. The contours in that hypothetical circumstance of any state law limitations were not before the lower court.

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22. The purpose of such "voluntary" institutionalization, should it be permitted at Pennhurst, is habilitation: "The Mental Health and Mental Retardation Act of 1966 regulates the voluntary admission for inpatient hospital habilitation of the mentally retarded." *Secretary of Public Welfare v. Institutionalized Juveniles*, 422 U.S. 640, 658 (1979).

23. *Goldy v. Beal*, 429 F.Supp. 640 (M.D. Pa. 1976), invalidated the state civil commitment statute and the state was without a mechanism for commitment of the retarded. To permit the legislature to consider the question, a stay was ordered by consent on October 28, 1976 and its provisions adopted and published as state regulations. 6 Pa. Bull. 2883 (Nov. 13, 1976).

2. It is argued that "treatment is not the only basis for commitment of the retarded under state law. To the contrary, the mentally retarded may be committed when they are 'in need of care or treatment.' Pa. Stat. Ann. Tit. 50, §§4406(a)." Brief for Petitioners at 42. *This statutory standard was ruled unconstitutional in 1976 and its use enjoined by a three-judge court in Goldy v. Beal, 429 F.Supp. 640 (M.D. Pa. 1976). No retarded person may be institutionalized in Pennsylvania except under procedures mandated in Goldy which necessitate a finding of dangerousness and, in addition, a finding that no community facility "can be made available."* Order of October 28, 1976, *Goldy v. Beal, supra; see* note 23 *supra*. Therefore, petitioners' second argument, founded on a non-existent statutory provision, falls.

3. County petitioners argue they have no responsibility for community programs because they are not specified in 50 Pa.C.S.A. §4301(d). Brief for Petitioners at 42. This argument ignores both the facts and other dispositive sections of the state law. Every county *must* establish a county retardation program, §4301(a), and that program is specifically granted the power to establish any "other service or program designed to prevent mental disability or the necessity of admitting or committing the mentally disabled to a facility." §4301(f). The mandated services which the petitioners concede are county duties include several which are the basis for community programs (*e.g.*, aftercare, specialized rehabilitative and training services, partial hospitalization). Beyond the statutes' interstices are the facts of this case and the counties' direct involvement. Notes 97a and 106a *infra*.

With a state law ground which is independent and sufficient in every respect, and which is articulated in

opinions below which are entirely reasonable, the judgment below must be affirmed.

III. In the Developmentally Disabled Assistance and Bill of Rights Act, Congress established rights including the right to individually determined habilitation in the appropriate least restrictive setting.

Initial Congressional reaction to overcrowed, obsolete facilities providing inappropriate services to the retarded was legislation beginning in 1963 providing financial aid to the states for construction and grants which simply encouraged community services. This approach did not work, Congress found, and after several years of intense study, many hearings and consideration of alternative legislative initiatives, Congress understood that the conditions under which retarded people are generally confined in institutions render impossible the fulfillment of the habilitation standard established as national policy. Therefore, in 1975, Congress departed from the existing laws' sole emphasis on funding and recognized specific rights. They enacted a Bill of Rights explicitly intended to eliminate the inappropriate institutional care to which Congress found a "vast majority of the developmentally disabled" were being subjected. With strengthened provisions in 1978, this consummate equal rights initiative, the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000 *et seq.*, is the federal statutory ground on which the Court of Appeals rested its judgment.

Title II of the Act, the "Bill of Rights" section, sets the standard by which equality is measured and enforced — the standard is provision of individually determined services in an appropriate setting — while Title I, the "Assistance" section, adopts a mechanism permitting states to draw upon other existing federal programs to meet the statutory obligations. Petitioners'

confusion of these separate provisions brutalizes both the plain meaning of the Act and its legislative history.

The discussion below begins with an analysis of the words of the statute. This is followed by a summary of the statutory predecessors to the current Act, a procedural history of the Bill of Rights provisions, and, finally, an analysis of the intent of Congress expressed in several years of legislative history.

A. The Plain Meaning of the Act Supports the Judgment Below.

It is axiomatic that statutory interpretation starts with the plain language of an enactment:

> What we have to do in this case is to find the meaning of some not very difficult words. We must try, I have tried, to do it with the same freedom of natural and spontaneous interpretation that one would be sure of if the same question arose upon an indictment for a similar act which excited no public attention, and was of importance only to a prisoner before the court. Furthermore, while at times judges need for their work the training of economists or statesmen, and must act in view of their foresight of consequences, yet when their task is to interpret and apply the words of a statute, their function is merely academic to begin with — to read English intelligently — and a consideration of consequences comes into play, if at all, only when the meaning of the words used is open to reasonable doubt.[24]

Where "Congress was aware of what it was doing and the legislative history does not demonstrate that the plain language was not intended," *Maine v. Thiboutot*,

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24. *Northern Securities Co. v. United States*, 193 U.S. 197, 400-401 (1904) (Holmes, J., dissenting).

____ U.S. ____ (1980), the usual meaning of a statute's words controls. *Mobil Alaska Pipeline Co. v. United States*, 436 U.S. 631 (1978). In such a case, this Court does not revisit the social policy questions determined by Congress. "The calculus of effects, the manner in which a particular law reverberates in a society, is a legislative and not a judicial responsibility." *Personnel Administrator of Massachusetts v. Feeney*, 442 U.S. 256, 272 (1979).[25]

Two purposes are evident in the title of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000 *et seq.*[26] First, to *assist* the developmentally disabled and, second, to provide the beneficiaries of the Act with a *Bill of Rights*.[27]

"Bill of Rights" are words with ringing import in our history; the phrase was familiar to those who settled in America. *See English Bill of Rights*, 1 Wm. & M., sess. 2, c. 2 (1689). By 1784, seven states had adopted discrete declarations or bills of rights and four others had singled out specific rights for incorporation into their constitutions.[28] A price for ratification of the Constitution was the new states' resolve to adopt a Bill of Rights, a task

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25. *See Switchmen's Union of North America v. National Mediation Board*, 320 U.S. 297, 301-302 (1943); *United States v. Crescent Amusement Co.*, 323 U.S. 173, 187-188 (1944).

26. "Where the mind labors to discover the design of the legislature, it seizes every thing from which aid can be derived; and in such case the title claims a degree of notice, and will have its due share of consideration." *Fisher v. Blight*, 6 U.S. 358 (1805) (*per* Marshall, Ch.J.). *Accord, United States v. Katz*, 271 U.S. 354, 357 (1926).

27. The title was not adopted casually. Three years after its enactment, Congress explicitly rejected an attempt to drop "Bill of Rights" and rename the law "Developmental Disabilities Act." 1978 U.S. Code Cong. & Admin. News 7415 (Conference Committee).

28. The seven states are Delaware, Maryland, Massachusetts, New Hampshire, North Carolina, Pennsylvania and Virginia; the four are Georgia, New Jersey, New York and South Carolina. *See* Thorpe, *Constitutions and Charters*.

accomplished in the First Session of Congress which approved the Bill of Rights on September 26, 1789. *Senate Journal*, 1st Sess. 150-151. *See*, Goebel, *History of the Supreme Court of the United States: Antecedents and Beginnings to 1801*, Ch. X, "Unfinished Business — The Bill of Rights" at 413-456 (1971).

It is the "numinous aura of the Bill of Rights," Goebel, *History, supra*, at 457, which is evoked by the title and provisions of the Act under consideration. Petitioners cite no evidence, and there is none, to indicate that Congress' choice of words was accidental, trivial or meaningless.

A "Bill of Rights" establishes rights;[29] the Act's various provisions identifying specific "rights" cannot reasonably be understood to refer to anything but rights.

B. The Statutory Predecessors of the Current Act

President John F. Kennedy initiated federal action to assist the mentally retarded with his establishment of the first President's Panel on Mental Retardation in the early 1960's.[30] Legislative response to the work of this commission was swift. The Congress found that comprehensive services to retarded citizens were needed and that existing facilities were overcrowded, obsolete and inappropriate[31] and enacted the Mental Retardation

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29. Congress headed Title II, "Establishment and Protection of the Rights of Persons with Developmental Disabilities." 89 Stat. 502. *See* 124 Cong. Rec. S2519 (Sen. Randolph), S15557 (Sen. Stafford), S15562 (Sen. Williams); notes 55-57, 59 *infra*.

30. *See* The President's Panel on Mental Retardation, *Report of the Task Force on Law* 10-12, 41 (1963).

31. H.Rep. No. 694, reprinted in 1963 U.S. Code Cong. & Ad. News 1054, 1061-1062. Preference for community services was apparent:

> Sheltered workshops can be of great assistance as a part of a comprehensive center organized to restore the mentally retarded to the maximum degree of normal living in his community. In the absence of a coordinated program of services, the mentally retarded person is denied the opportunity to develop most fully his potential for contributing to our society.

Id at 1061.

Facilities and Community Mental Health Centers Construction Act of 1963, P.L. 88-164, 77 Stat. 282 (1963), to provide funds for construction of new facilities and for the development of community facilities.

The 1963 Act was revised and extended by the Mental Retardation Act of 1967 which added a grant program to train professionals in community retardation programs to avoid institutionalization and continued fiscal support of community programs and comprehensive services for the retarded.[32]

A 1970 law introduced the formula grant system still in use under the present Act and expanded the scope of the law to include as beneficiaries the developmental disabilities (mental retardation, epilepsy, cerebral palsy and autism). Developmental Disabilities Services and Facilities Construction Amendments of 1970.[33]

Adding an entirely new dimension to the existing funding statute, the Bill of Rights was enacted in 1975 in the Developmentally Disabled Assistance and Bill of Rights Act[34] which, with its 1978 amendments,[35] is discussed below.

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32. The developmental potential of the retarded was noted:

> The mentally retarded can be educated to be useful citizens, self-supporting and free of institutional care. . . . Our aid to the mentally retarded can mean the difference between their being a whole human person and being an impersonal statistic in an institution.

1967 U.S. Code, Cong. & Ad. News 2071. *See also*, Mental Retardation Amendments of 1967, Hearing Before the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, on S.1099 and H.R. 643 and S.389; Mental Retardation and Other Developmental Disabilities, 1969, Hearings Before the Subcommittee on Health of the Committee on Labor and Public Welfare, U.S. Senate, on S.2846. The 1967 statute is at P.L. 90-170, 81 Stat. 527, extended, P.L. 91-517, 84 Stat. 1316.

33. P.L. 91-517, 84 Stat. 1316 (1970).

34. P.L. 94-103, 89 Stat. 502 (1975).

35. Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978, Title V, P.L. 95-602, 92 Stat. 2955 (1978).

C. Procedural History of the Bill of Rights

A decade after enactment of the Mental Retardation Facilities and Community Mental Health Centers Act of 1963, the Bill of Rights was presented to the Senate as S.458, a Bill of Rights for the mentally retarded.[137] The country had been shaken by media exposure of conditions at Willowbrook and other institutions and the bill's sponsor, Sen. Jacob Javits, responded with this proposed legislation to insure habilitation by establishment of standards for residential facilities and minimizing inappropriate admissions to institutions such as the one in his home state of New York. 1973 Hearings, cited *infra* note 36, at 229-230; 121 Cong. Rec. 29820 (Sen. Javits); Developmentally Disabled Assistance and Bill of Rights Act, 1974, Hearings Before the Subcommittee on the Handicapped of the Committee on Labor and Public Welfare, U.S. Senate, on S.3378 at 273 (Sen. Kennedy) (hereafter, 1974 Hearings).

S.458 was followed in 1974 by S.3378 which was substantially equivalent to the prior bill,[37] S. Rep. 94-160 at 3-4, with Congressional interest further provoked by the study by the General Accounting Office, performed under the 1970 Act, which revealed continuing serious gaps in services to the retarded, with disparities among the states and within the states. 1974 Hearings at 1-2; 121 Cong. Rec. 29817 (Sen. Randolph). The bill's purpose continued to be establishment of habilitation

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36. *See* S.Rep. 94-160 at 3-4. S.458 and its grant counterpart S.427 are reprinted in Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973, Hearing Before the Subcommitee on the Handicapped of the Committee on Labor and Public Welfare, U.S. Senate, on S.427 and S.458, (hereafter, 1973 Hearings).

37. S.3378 extended the standards of S.458 to community facilities. 1974 at 273 (Sen. Kennedy). S.3378 is reprinted in the 1974 Hearings.

standards and redirection away from institutionalization.[38]

The parent of the Bill of Rights in its current form is S.462, under which S.3378 was reintroduced in the 1975 legislative season.[39] Like its predecessors, S.462 set forth detailed standards for residential and community programs. As discussed in detail in the next section, following hearings, Senate Report 94-160 issued. Passed by the Senate, S.462 went to the House and the matter was referred to a Joint Committee.[40] The various provisions were distilled into their current form and became law as P.L. 94-103, 89 Stat. 496, Title II.

In 1978, when the planning program of the "assistance" section of the Act, Title I, was substantially revised (although not redirected), the Bill of Rights, Title II, was unchanged, except for Congress' addition of a special emphasis that the rights in the Bill of Rights were in addition to rights possessed by all persons. Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, P.L. 95-602, Title II, §507, 92 Stat. 3007 (1978).

D. Congressional Intent to Create Enforceable Rights Is Manifest in the Legislative History of the Act.

The legislative process, including three years of hearings, extensive debate and study of institutions and their alternatives, demonstrates the studied intention with which Congress abandoned a purely encouragement-funding strategy and adopted an enforcement-rights solution.

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38. S.3378, Title II, §201, reprinted 1974 Hearings at 44.

39. S.462 is reprinted in Developmentally Disabled Assistance and Bill of Rights Act, 1975, Hearings Before the Subcommitee on the Handicapped of the Committee on Labor and Public Welfare, U.S. Senate, on S.462 (hereafter, 1975 Hearings).

40. H. Conf. Rep. 94-473, reprinted 1975 U.S. Code & Ad. News 943.

42 U.S.C. §6010, the Bill of Rights, codifies "a right to appropriate treatment, services and habilitation," §6010(1), "designed to maximize the developmental potential of the person," and "provided in the setting that is least restrictive." §6010(2).[41]

"[P]ublic funds" of both the "Federal Government and the States" cannot be provided to institutional or other residential programs which do not meet specific minimum standards. §6010(3). There is no dispute in this case that Pennhurst violates each of the standards in §6010(3).

Parts (1) and (2) of §6010 emphasize the *individual* rights of disabled people and part (3) is focused on the *institution*.

§6010(4) looks to "all programs" (not residential facilities alone) and specifies certain standards. §6010 closes with a pointed reminder that the disabled have other rights in addition to those under the Act.

1. *Congressional Findings*

Every finding of the lower courts is matched by a congruent prior finding of the Congress:

> 1. Mental retardation is an educational handicap, not a disease; retarded people are not subhuman, objects of pity, eugenic misfits or eternal children. S. Rep. 94-160 at 27-28; 446 F.Supp. at 1298; 10a-13a.
>
> 2. In the history of the retarded, misconceptions and myths resulted in segregation, sterilization, stigmatization and institutionalization of retarded people. S. Rep. 94-160 at 26-27; 1973 Hearings at 253; 446 F.Supp. 1299-1300; 11a-13a.
>
> 3. Congress adopted the developmental model of services to retarded people, finding that, with

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41. Reprinted at Petition for Certiorari of Pennhurst Parents-Staff Association at 182-183a of the Appendix therein.

proper habilitation, every retarded person is capable of growth toward the goal of self-sufficiency; therefore custodial care "must be rejected." S. Rep. 94-160 at 28;[42] 446 F.Supp. at 1298; 10a.

4. Despite a decade of federal funding for institutions, deplorable conditions and scandals prompting litigation continued to affect such facilities; dramatic changes were required. S. Rep. 94-160 at 3, 28; 446 F.Supp. at 1314-1322; 48a-66a.[43]

5. Persons forced to vegetate on wards of institutions become further physically and mentally handicapped. S. Rep. 94-160 at 28; 1973 Hearings at 229-230; 446 F.Supp. at 1304-1310; 34a-40a.

6. State officials conceded that inhumane and non-habilitative conditions plague institutions. S.

42.

> Such a view stresses that all developmentally disabled individuals have potential for learning and growth.
>
> From this developmental model, it follows that custodial care — which is predicated on the assumption that certain individuals are essentially incapable of development — must be rejected. The newer developmental model emphasizes concrete program goals for individuals and therefore encourages evaluation based on specific outcomes.

S. Rep. 94-160 at 28. *See* 1967 U.S. Code & Ad. News 2071; 124 Cong. Rec. 15562 (Sen. Williams); 124 Cong. Rec. S15571 (Sen. Dole).

43.

> The past four years have seen a dramatic increase in public awareness of the needs of institutionalized mentally retarded or developmentally disabled persons. This has been highlighted by scandals in a number of institutions, by court cases, and by some excellent work in the mass media. Testimony before this Committee persuasively demonstrated that implementation and enforcement of minimum standards of care in institutions for the developmentally disabled are urgently needed and that the Federal Government can and should play a significant role in upgrading the care and services provided to developmentally disabled persons in public and other facilities which operate with Federal funds.

S. Rep. 94-160 at 3.

Rep. 94-160 at 32; 446 F.Supp. at 1313; 47a; 612 F.2d at 92; 103a.[44]

7. Institutions do not provide habilitation. S. Rep. 94-160 at 16, 28, 30, 32-33 (". . . it is not, however, the Committee's intent that enactment of this title should be construed in any way to constitute support of institutionalization of the mentally retarded." *Id.* at 33); 446 F.Supp. at 1318; 58a.[45]

8. Institutions are dangerous. 1973 Hearings at 567 (Sen. Kennedy); S. Rep. 94-160 at 28 (contractures), 30 (drugs); 446 F.Supp. at 1304-1310; 34a-40a.

9. "Most of the institutions themselves are anachronisms, and . . . rapid steps should be taken to phase them out." S. Rep. 94-160 at 32-33; 1973 Hearings at 253; 446 F.Supp. at 1318; 58-59a.[46]

44.

> The inhumane and nonhabilitation aspects of these large institutions have unfortunately been graphically demonstrated over and over again. In a number of crucial court cases, for example, the defendants were only too willing to stipulate that the conditions described by the plaintiffs were accurate.

S. Rep. 94-160 at 32.

45.

> . . . most large institutions for the mentally retarded and developmentally disabled in the United States lack individualized treatment plans and programs. That is, care is primarily custodial; and little attention is paid to the residents' potential for increased self-care, ability to use education and training.

S. Rep. 94-160 at 30. Institutions "lack any commitment to change and have not accepted the developmental model described above." *Id.* at 28.

46.

> Efforts to assure people treatment, education and habilitation services in large institutions should not deflect attention from the fact that most of the institutions themselves are anachronisms, and that rapid steps should be taken to phase them out. Many of these institutions by their very nature, their size, their isolation, their impersonality, are unsuited for treatment, education and habilitation programs.

10. Reducing institutional population is not sufficient; creation of community services is the necessary remedy. S. Rep. 94-160 at 30; 121 Cong. Rec. 16516 (Sen. Williams); 1973 Hearings at 563; 121 Cong. Rec. 9965 (Rep. Young); 121 Cong. Rec. 9977 (Rep. Carter); 446 F.Supp. at 1312; 43a.[47]

11. The "vast majority of persons now institutionalized should not be in these institutions at all," S. Rep. 94-160 at 33, and those people require individual determinations of what they need. 1973 Hearings at 254, 563; H. Conf. Rep. 94-473 at 32-33, reprinted 1975 U.S. Code & Ad. News 943, 952; S. Rep. 94-160 at 30; 121 Cong. Rec. 9977 (Rep. Carter); 446 F.Supp. at 1311-1312; 43a; 612 F.2d at 115; 156a-159a.

12. Normalization is integral to habilitation for retarded people and it must occur, by definition, in the least restrictive environment appropriate to the individual. Thus, habilitation includes the "least restrictive" requirement. S. Rep. 94-160 at 28; 1973 Hearings at 564; 446 F.Supp. at 1318; 58a; 612 F.2d at 93; 105a.[48]

NOTE 46 — *(Continued)*

S. Rep. 94-160 at 32-33. "Many of the institutions can best be described as 'hopeless places' dedicated to custodial care of life-long residents." *Id.* at 28.

47. Congressional support for community services for severely handicapped people was reaffirmed in its funding of centers for independent living under the 1978 amendments to the Rehabilitation Act. P.L. 95-602, cited noted 35 *supra*.

48.

> A final, but critically important dimension of this new model is that developmentally disabled persons should live like non-developmentally disabled persons to the greatest extent possible. Every effort should be made to assist developmentally disabled persons to maximize their ability for self-care and to live normal lives. From this it also follows that each developmentally disabled person should be allowed to live in the least restrictive environment conducive to his or her maximum development.

S. Rep. 94-160 at 28.

13. Aware of the unnecessary expense of institutions, particularly where no habilitation is provided,[49] Congress expected the states to further develop alternatives for the disabled,[50] and Congress also expected that development of community services, and the use of hundreds of millions of dollars from other federal programs,[51] would free more state dollars for community care.[52] It is of no import that the Bill of Rights itself does not fully fund the rights created thereby; the explicit intention was to

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49. 124 Cong. Rec. S15661 (Sen. Muskie); 121 Cong. Rec. 9978 (Sen. Biaggi); 1973 Hearings at 254, 565; 124 Cong. Rec. S18996 (Sen. Randolph).

50. S. Rep. 94-160 at 33. The extensive planning required of states under the funding provisions would be meaningless without state support of the services planned. *E.g.*, §6063(a)(20) (plan to eliminate institutional placements); §6063(a)(21) (programs for infants and preschool children); §6063(a)(23) (support for community programs). More specific means of securing state action were included in the 1978 amendments for the purpose of increasing the impact of federal dollars on the state system. H. Rep. 95-1188 at 9-10. *See*, the §6000(a)(5) (". . . it is in the national interest to strengthen specific programs, especially programs that reduce or eliminate the need for institutional care . . ."); §§6063(b) and 6001(8) (priority services exclude institutional care).

51. $800,000,000 in federal funds assisted the developmentally disabled in 1974. 1974 Hearings at 275. Institutions for the retarded received $490,000,000 that year. *Id.* at 291. *See* note 52 *infra*.

52.

> It is hoped that corresponding amounts of State and other funds currently being spent on institutional care will be rebudgeted for community care, an obvious rebudgeting which has not always occurred in conjunction with deinstitutionalization efforts.

H. Rep. 94-58 at 10. Congress provided funding supplemental to that of the states, *see Harris v. McRae*, 48 U.S.L.W. 4941, 4944 (1980), to assist in enforcement of the Bill of Rights. Having found that developmentally disabled persons were often excluded from funding programs, H. Rep. 95-1188 at 7; S. Rep. 94-160 at 26-28;

lever the already available funds. Notes 150, 151, 152, and 153 *infra*.[53]

14. Institutionalization is permitted only where "absolutely necessary," S. Rep. 94-160 at 16, and where the institution is one which can meet the needs of the proposed resident. *Id.* at 1, 33; 121 Cong. Rec. 16520 (Sen. Javits).[54]

2. *Congress Intended to Codify Those Civil Rights Established By the Courts.*

As it considered passage of the Bill of Rights Act, Congress knew that institutional conditions remained

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NOTE 52 — *(Continued)*

42 U.S.C. §6000(a)(4), Congress created an interstitial program to fill the gaps between federal programs. H. Rep. 95-1188, reprinted, 1978 U.S. Code Cong. & Ad. News at 7543; §§6063(b)(2)(B) and §6066; 124 Cong. Rec. H9986. ("Actually most of the funds from this program are not to be spent on direct services payment. Instead they are used to provide access and 'tap into' existing programs to improve their ability to serve the 'D.D.' population."; 121 Cong. Rec. 29820 (Sen. Schweiker). HEW's expenditures for retardation in 1975 were $1,531,000,000. Comptroller General, Report to the Congress, *Returning the Mentally Disabled to the Community: Government Needs to Do More* 231 (1977). For fiscal 1980, HEW's retardation expenditures were more than $3,000,000,000. HEW, *Special Report: Mental Retardation*, Hearings before the Subcommittee on Departments of Labor, HEW and Related Agencies of the House Committee on Appropriations, 96th Cong., 2d Sess., Part 2, at 641-44, 673. *See* note 51. Introducing the 1978 amendments, Sen. Stafford declared, "There should be no cost limits on helping handicapped individuals to live free in a democratic society." 124 Cong. Rec. S2521.

53. For Pennhurst, where sufficient funds are available under state law, there can be no reason to avoid or delay effectuation of Congressional intent.

54. *See* 121 Cong. Rec. 16470, 16516-16517 (Sen. Williams); 121 Cong. Rec. 16552 (Sen. Beall); *Id.* (Sen. Schweiker) 121 Cong. Rec. 16520 (Sen. Cranston) ("where institutional programs are appropriate . . . habilitation programs can be given residential patients to develop their fully potential.")

abominable, 1973 Hearings at 562-563, and that "[e]ncouraging, but limited progress ha[d] been made under the present law." S. Rep. 94-160 at 2 (P.L. 90-170). Congress decided to strengthen the existing law, 121 Cong. Rec. 29821 (Sen. Williams), by establishing a statutory right to habilitation, following the lead of the federal courts:[55]

> Title II is designed to assist in the protection of the human rights guaranteed under the Constitution of those mentally retarded and other developmentally disabled individuals who require institutional care or need community facilities and programs.

S. Rep. 94-160 at 34.

After passage by the Senate, the Bill of Rights finally emerged from the Joint Conference Committee in its present distilled form.[56] Title II, headed "Establish-

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55. S. Rep. 94-160 at 2-3, 30-33; 121 Cong. Rec. 16515 (Sen. Randolph); *id.* at 16516 (Sen. Stafford), 16516-16517 (Sen. Williams), 16519 (Sen. Javits), 16522 (Sen. Beall), and 16522 (Sen. Taft); 1973 Hearings at 250. S. 462's standards, later condensed into §6010, were the "absolute minimum" so as not to "violate the Constitutional rights of the individuals in those programs." S. Rep. 94-160 at 38 ("violation of their human and civil rights"). Note 29 *supra*.

56. H.Conf. Rep. 94-473, reprinted, 1975 U.S. Code Cong. & Ad. News 943 (1975).

The Conference Committee's "more general, yet equally forceful, Bill of Rights," 612 F.2d at 97; 113a, was not, as petitioners assert, in derogation of the rights to habilitation. It was, rather, a response to concerns of the Department of Health, Education and Welfare and others that the detailed inflexible standards of S. 3378 (the 1974 predecessor to S. 462) would interfere with the ICF/MR certification of facilities and, more importantly, would unwisely shift attention to the *institution*, rather than to the *individual* requiring services. 1974 Hearings at 285, 288-289, 292 (HEW Assistant Secretary), 389-390 (National Association for Retarded Citizens), and 407 (United Cerebral Palsy Association); 1973 Hearings

ment and Protection of the Rights of Persons with Developmental Disabilities," opens with Section 111, 42 U.S.C. §6010, "Rights of the Developmentally Disabled." 89 Stat. 502. The intention had not altered a whit; Congress was determined to codify the right to habilitation. *E.g.*, 121 Cong. Rec. 16510-16520 (Sen. Javits); 121 Cong. Rec. 29309 (rep. Rogers); H. Conf. Rep. 94-473, at 41, 42, reprinted 1975 U.S. Code Cong. & Ad. News 943, 961, 962.[57]

That enforceable rights were established is apparent in the consideration of the 1978 amendments:

> As lawmakers and as citizens we must help protect the rights of these severely and profoundly handicapped persons. Equity for severely handicapped individuals is essential to our national security. . . . Our work on this measure affirms not only the rights of these severely handicapped individuals but also strengthens the rights and protection of all citizens.

124 Cong. Rec. 15547 (Sen. Randolph).

The Bill of Rights Act also required creation of an independent system for "Protection and Advocacy of In-

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NOTE 56 — *(Continued)*
at 556 (Sen. Kennedy), 1975 Hearings at 434, 437 (HEW). Section 6010 acknowledges the difference between an outcome measurement for individuals (the right to habilitation) and institutional standards.

57. "These rights are generally included in the conference substitute in recognition by the conferees that the developmentally disabled, particularly those who have the misfortune to require institutionalization, have a right to receive appropriate treatment for the conditions for which they are institutionalized, and that this right should be protected and assured by Congress and the courts." H. Conf. Rep., *supra* note 56, at 42. "The conference substitute contains a compromise which specifies *rights*. . . ." *Id.* at 41 (emphasis added). *See* 121 Cong. Rec. 29818 (Sen. Randolph); 121 Cong. Rec. 29821 (Sen. Williams). Note 29 *supra*.

dividual Rights," 42 U.S.C. §6012, Title II, §203, 89 Stat. 504, with authority to pursue "legal . . . remedies" to protect "rights" of persons receiving "habilitation." Surely Congress was here guaranteeing that the rights it established would not be written in air and that severely disabled people who are sometimes limited in ability to advocate on their own behalf would have an effective voice.

IV. A judicial remedy is provided to developmentally disabled people for official deprivation of rights under the Developmentally Disabled Assistance and Bill of Rights Act.

Developmentally disabled people may assert their rights, and federal courts may provide a remedy, under either 42 U.S.C. §1983 or an implied private right of action. Both these alternatives are available to effectuate the Congressional intention that people such as those confined at the Pennhurst institution have their day in court.

A. Remedy under 42 U.S.C. §1983

In a case over which a court has jurisdiction,[58] 42 U.S.C. §1983 provides a remedy for official deprivation of federal statutory rights. *Maine v. Thiboutot*, ____ U.S. ____ (1980). The Bill of Rights Act establishes substantive rights to individualized habilitative services, §6010(1), and to an appropriate habilitative environment, §6010(2). The power of Congress to establish such rights is not disputed by petitioners, although they deny Congress' intention to do so. That power, however,

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58. Jurisdiction is not disputed by petitioners. The private plaintiffs raised substantial constitutional and pendent state claims, *Hagans v. Levine*, 415, 528, 536, 543 (1974); 28 U.S.C. §1343(3), and damage claims, 28 U.S.C. §1331.

is clear and stems from two alternative sources, Congress' Section 5 and its spending power.

Legislation enacted pursuant to Section 5 of the Fourteenth Amendment may impose severe restraints on state action and discretion. *Fitzpatrick v. Bitzer*, 427 U.S. 445 (1976), with the Court giving great deference to Congressional findings that particular steps are "appropriate" exercises of legislative authority. *Regents of University of California v. Bakke*, 438 U.S. 265, 302 n. 41 (1979) (collecting cases); *McCulloch v. Maryland*, 17 U.S. 316, 421 (1819); *Ex parte Virginia*, 100 U.S. 339, 345-346 (1880). Congress intended the Bill of Rights Act to enforce the Fourteenth Amendment.[59]

Rights violated at Pennhurst and encompassed in the Act include those to receive more than zero education, *Rodriguez v. San Antonio School District*, 411 U.S. 1 (1973), personal security, *Ingraham v. Wright*, 430 U.S. 651, 673 (1977), institutionalization the nature and duration of which bear a reasonable relation to its purpose, *Jackson v. Indiana*, 406 U.S. 715, 738 (1972), freedom from custodial care for non-dangerous persons capable of living safely with assistance outside the institution, *O'Connor v. Donaldson*, 422 U.S. 567, 576 (1975), and freedom from training and education in separate stigmatizing and unequal facilities, *Brown v. Board of Education*, 356 U.S. 148 (1954).

Having accepted federal funds under the Bill of Rights Act for its unified state-county retardation program, Pennsylvania must comply with the requirements imposed by Congress under its spending clause powers.

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59. 612 F.2d at 98 n. 17; 117a n.17; notes 29, 55-57 *supra*; S.Rep. 94-160 at 32; H.R. Rep. 95-1188 at 7; H.R. Conf. Rep. 94-473 at 42, reprinted, 1975 U.S. Code, Cong. & Ad. News 943, 961. The legislation was prompted by the conditions of the disabled and judicial recognition of their constitutional rights; the Bill of Rights was intended to codify and implement such rights. *See Oregon v. Mitchell*, 400 U.S. 112 (1970).

612 F.2d at 98-99 n. 20, 21; 118a-119a n. 20, 21; *Helvering v. Davis*, 301 U.S. 619 (1937); *Rosado v. Wyman*, 397 U.S. 397 (1970). *Cf., National League of Cities v. Usery*, 426 U.S. 833, 853 n. 17 (1976); *Miller v. Youakim*, 440 U.S. 125 (1979).

Petitioners grasp at straws when they inject in their briefs a question on which certiorari was not granted: whether the Bill of Rights Act can be enforced exclusively by a federal funding cut-off by the Secretary of Health and Human Services on her own or under court order. The "power to cut off federal funds for noncompliance with statutory requirements," a power resting with federal departments under every federal-state cooperative program, has repeatedly been "considered and rejected" by the Court as a basis upon which to deny judicial power to review state action. *Rosado v. Wyman*, 397 U.S. 397, 420 (1979); *Cannon v. University of Chicago*, 441 U.S. 677 (1979).[60] Congress intended the Bill of Rights Act to support and encourage legal action by disabled people themselves.[61] A system was established to protect and advocate the rights of

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60. *See Regents of University of California v. Bakke*, 438 U.S. 265, 419 n. 26 (1979) (opinion of Stevens, J.); *Chapman v. Houston Welfare Rights Organization*, 441 U.S. 600, 672 (1972) (White, J., concurring).

61. Notes 29, 43 *supra*. Congress fully expected judicial enforcement of §6010, declaring that "this right should be protected and assured by Congress and the courts." H. Conf. Rep. 94-473 at 42, reprinted, 1975 U.S. Code, Cong. & Ad. News 943, 961. Congress was aware and approved of institutional disability litigation, S. Rep. 94-160 at 34, and knew that "all indications point toward little change unless substantial legal and advocacy pressure is forthcoming." 121 Cong. Rec. 16516 (Sen. Williams, citing litigation).

> Mr. President, this is a program which I think is strongly needed. I do not know how many times we have had television documentaries on Willowbrook, and Forest Haven, and other institutions in this Nation, and still nothing gets done. The public looks at these various programs and they absolutely deplore the conditions that, in too many instances, have been the lot of the people that are covered by this legislation.

disabled people through pursuit of legal remedies,[62] and, in 1978, Congress amended §6010 to express that the rights there specified "are in addition to any constitutional or other rights afforded to all persons."[63] There being no word or phrase in the legislation or history even hinting at an intention to lodge exclusive enforcement in a funding cut-off remedy, it cannot be concluded that "Congress has closed the avenue of effective judicial review to those individuals most directly affected by the administration of its program." *Rosado v. Wyman*, 397 U.S. at 420.[64]

NOTE 61 — *(Continued)*

> Everyone in here knows that the only way that change is going to be brought about is the long difficult, persistent and dedicated advocacy of those who are prepared to follow through administrative hearings, through hearings on regulations, through challenges in the courts, for the kinds of rights which are being guaranteed in this legislation. That is the way it is done.

124 Cong. Rec. S15662-S15663 (Sen. Kennedy).

62. 42 U.S.C. §6012. "Let us remember that the current developmentally disabled population totals over 2 million very severely handicapped individuals, most of whom cannot effectively communicate their needs or even realize that their basic rights are being violated." 124 Cong. Rec. S15663 (Sen. Kennedy).

63. H. Rep. 95-1188 at 7, reprinted, 1978 U.S. Code, Cong. & Ad. News 7373. An intent of the Act is "to secure and protect their legal and human rights." *Id.* at 7362.

64. Congressional concern for "the inhuman way we care for such persons," 121 Cong. Rec. 16516 (Sen. Williams), was elevated because so little had changed. "The shocking conditions at Willowbrook in New York, and many other institutions for the mentally retarded throughout the Nation which inspired the bill of rights have not ended." 121 Cong. Rec. 16518 (Sen. Javits). The drastic last-resort funding cut-off remedy, accomplished in a process not admitting the disabled as parties of right, cannot in any event secure habilitative services to which people are entitled. These personal rights are secured not through shutting down programs which transgress the law but by injunctive relief to end the violation itself. *Cannon v. University of Chicago, supra; Regents of University of California v. Bakke, supra; Lau v. Nichols*, 414 U.S. 563 (1974); *Hills v. Gautreaux*, 425 U.S. 284 (1976).

The Secretary's authority to cut off program funds can be exercised only in the extreme circumstance where an entire program fails; that authority is an insufficiently delicate instrument to vindicate particular individuals' personal rights. And it is personal rights which are the concern of §§6010(1) and (2). No provisions of the Bill of Rights Act spotlight individual rights with greater intensity than §§6010(1) and (2) which, by their terms, apply to all "persons with developmental disabilities." By contrast, §6010(3) looks to "institutions" and "programs" and sets standards Congress knew to fall short of the §§6010(1) and (2) individual rights:

> The Conference Committee recognizes that the six minimum standards [§6010(3)] are designed to protect the basic human needs of developmentally disabled individuals and *will not in themselves ensure quality habilitation and adequate programs.*

H. Conf. Rep. 94-473 at 43 (emphasis supplied).[65]

B. Private Right of Action

An independent though consistent alternative to §1983 which provides a judicial remedy for respondents is their implied private right of action under the Bill of Rights Act itself. The question is "one of statutory construction" and the Court's "task is limited solely to determining whether Congress intended to create the private right of action asserted. . . ." *Touche Ross & Co. v. Redington*, 442 U.S. 560, 568 (1979).

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65. *E.g., Allen v. State Board of Elections*, 393 U.S. 544, 556 (1969) ("The achievement of the Act's laudable goal could be severely hampered, however, if each citizen were required to depend solely on litigation instituted at the discretion of the Attorney General."). *Cannon v. University of Chicago, supra*, 441 U.S. at 710, 706 n. 41. As in *Allen*, it is here "significant that the United States has urged that private litigants have standing to seek declaratory and injunctive relief in these suits." 393 U.S. at 557 n. 23.

Cases finding implied private remedies have set forth indicia for taking the measure of statutes. A private remedy is implied where "the statute in question at least prohibited certain conduct or created federal rights in private parties"[66] but not implied where the duties of defendants are "for the benefit of the public at large"[67] or some party other than the plaintiff.[68] A private remedy is implied where it "make[s] effective the congressional purpose"[69] but not implied where Congress has selected other specific exclusive enforcement machinery.[70] A remedy is implied where the right will thereby be enforced[71] but not where no enforcement will result.[72] Finally, a remedy is implied "for the enforcement of civil rights, even when Congress has spoken in purely declarative terms."[73]

The Bill of Rights Act passes muster under these criteria. It is a civil rights law enacted to benefit a particular class and a private action will generate enforcement action in accordance with the policies and expectations of Congress.

Cort v. Ash, 422 U.S. 66, 78 (1975), provides the familiar template for analysis of this question. 446 F.2d at 97-98; 114a-122a. In the discussion which follows, references to the legislative history, examined exten-

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66. *Touche Ross*, *supra*, 442 U.S. at 569; *Cannon*, *supra*, 441 U.S. at 690 n. 13.

67. *Cannon*, *supra*, 441 U.S. at 690 n. 13.

68. *Piper v. Chris-Craft Industries*, 430 U.S. 1 (1977).

69. *J. I. Case v. Borak*, 377 U.S. 426, 433 (1964).

70. *Securities Investor Protection Corp. v. Barbour*, 421 U.S. 412 (1975); *National Railroad Passenger Corp. v. National Association of Railroad Passengers*, 414 U.S. 453 (1974); *Calhoun v. Harvey*, 379 U.S. 134 (1964); *Switchmen's Union of North America v. National Mediation Board*, 320 U.S. 297 (1943).

71. *Allen v. State Board of Elections*, 393 U.S. 544 (1969).

72. *Securities Investor Protection Corp. v. Barbour*, 421 U.S. 412 (1975).

73. *Cannon*, *supra*, 441 U.S. at 690 n. 13.

sively above, is omitted. The four *Cort* factors are satisfied in this case:

1. *Especial beneficiaries*. No party to the litigation disputes that the retarded are among the developmentally disabled and thus "especial beneficiaries" of the act. 42 U.S.C. §6001(7) (definition of developmental disabilities).

2. *Congressional intent*. Congress, recognizing that an administrative cut-off of funding would not sufficiently protect the individual rights under §§6010(1) and (2) made specific its intention to create a remedy in a private cause of action. That section of the Act was added in 1975, long after the 1963 origin of the funding statute. This addition was explicitly to protect the rights recognized by the courts and the legislative history fully confirms that Congress expected continued judicial enforcement of the rights enumerated in the statute, especially the right to habilitation. *Naughton v. Bevilaqua*, 458 F.Supp. 610, 616 (D.R.I. 1978).[74] It is correct to presume that Congress had no intention of changing the means of enforcement of the rights when it had such knowledge of precedent. *Cannon, supra*, 441 U.S. at 696.

3. *A private remedy is not inconsistent with the underlying purpose of the legislative scheme*. The legislative scheme and recognition of a private right of action are consistent with one another. It is "necessary or at least helpful" to the fulfillment of the statutory purpose for individuals to be able to enforce the Act in court.

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74. In addition, Congress required the states to create a system for protection and advocacy of the individual rights of developmentally disabled persons with the authority to pursue "legal, administrative and other appropriate remedies" for such individuals. 42 U.S.C. §6012(a)(2)(B). With such a provision, it cannot be denied that Congress expected disabled persons, and the advocacy system on their behalf, to assert both statutory and constitutional rights in private actions. *See* note 62 *supra*.

Cannon, supra, 441 U.S. at 703. Congress specifically reiterates its desire that the states insure the protection of the legal and human rights of the developmentally disabled and the provision of services to allow them to reach their potential. 42 U.S.C. §6000(b)(1). As is the case with other civil rights acts, the purpose of the Act is both to avoid the use of funds for illegal and unconstitutional purposes and to protect individuals against the effects of such practices. *See Cannon, supra*, 441 U.S. at 704; *Naughton v. Bevilaqua*, 458 F.Supp. 610, 616 (D.R.I. 1978):

> [W]ithout a private right of action to focus on and redress individual past violations and deter future ones, the guarantees promised by the Act would have little meaning. A remedial scheme that addressed only institution-wide wrongs and ignored individual wrongs would be inconsistent with Congress' central concern to correct the past neglect by large institutions of individual rights and differences in needs and potential.

4. *The cause of action is not one traditionally relegated to state law.* A cause of action to provide developmentally disabled people with services to meet their habilitative needs is not one traditionally of state law. Naughton, supra, 458 F.Supp. at 617. Congress was aware that such actions have been brought in federal courts for many years under the Constitution and federal statutes. Although federal and state interests in the well-being of the disabled overlap,[75] 446 F.2d at 98; 116a, the particular §6010 cause of action has no counterpart in state law and cannot be said to be "traditionally relegated" to the states; there is no reason to forbid federal

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75. Every state has laws consistent with the Bill of Rights Act. *See* table at 70 *infra*.

courts to act upon the separate federal interests it is Congress' duty to articulate.[76]

Legitimate state concerns are not impaired by an implied remedy. Persons claiming an official denial of habilitation must show a causal connection between the injury and the allegedly wrongful conduct. *Rizzo v. Goode*, 423 U.S. 362 (1976). State officials are entitled to a qualified immunity for actions undertaken in good faith.[77] *O'Connor v. Donaldson*, 422 U.S. 563 (1975). Persons actually injured by denial of care, however, will be entitled to injunctive relief ensuring future habilitation. *See Edelman v. Jordan*, 415 U.S. 651 (1974).

V. Where petitioner government officials adamantly refuse to remedy their violations of respondents' rights and where protection of state and federal statutory rights would otherwise be impossible, individual determinations of need and appointment of a master with circumscribed supervisory duties does not violate principles of federalism and is not an abuse of discretion.

Faced with an adamantine refusal by the petitioners "to devise and present their own remedies for conditions at Pennhurst," 612 F.2d at 112; 150a[78] the trial court

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76. "When [federal] money is spent to promote the general welfare, the concept of welfare or the opposite is shaped by Congress, not the states." *Helvering v. Davis*, 301 U.S. 619, 645 (1937) (Cardozo, J.), quoted in *Rosado v. Wyman*, 397 U.S. 397, 423 (1970) (Harlan, J.).

77. The named plaintiffs were denied damages in this case. 446 F.Supp. at 1324; 73a-75a.

78. After liability was determined on December 23, 1977, District Judge Broderick repeatedly attempted to obtain the cooperation of petitioners in formulating relief "tailored to cure the 'condition that offends' " the law. *Milliken v. Bradley*, 433 U.S. 267, 283 (1977), quoting *Milliken v. Bradley*, 418 U.S. 717, 738 (1974). The best the petitioners were willing to propose was "the same plan introduced by them at the trial in May, 1977," a plan which was "vague and indefinite." 446 F.Supp. at 1325; 78a (recounting the court's efforts to defer to petitioners proposals).

"on the basis of nine weeks' testimony in this case and the submissions of all parties, finds that the implementation of this Order will be impossible without the appointment of a Special Master. . . ." 446 F.Supp. at 1326; 80a-81a.[79] A master was appointed pursuant to Rule 53, Federal Rules of Civil Procedure, and the court's equitable powers.

Rather than wrest control of the retardation system from petitioners, the court carefully sculpted a minimal planning and supervisory role for its Master:

> As we understand the role of the Master under the decree, he is to supervise all implementation efforts with the aid and assistance of all parties to the lawsuit. The defendants will thus have an opportunity to participate in the structuring of relief.

612 F.2d at 112; 151a. In addition, the Court of Appeals found "it is only fitting that the Commonwealth be required to undertake a case-by-case investigation into how each person's rights may best be facilitated,"[80] requiring the District Court or Master to provide "individual determinations . . . as to the appropriateness of an improved Pennhurst for each such patient."[81]

A. Equitable Discretion Permits Choice Among Acceptable Alternative Structures for Relief.

This Court invariably recognizes the broad discretion which must be permitted lower courts in the sensitive and delicate task of fashioning relief, once liability has been determined. *E.g., United States v. Crescent Amusement Co.*, 323 U.S. 173, 185 (1944) ("where findings of violations are sustained, we will not direct a

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79. The record below demonstrated that, for decades, petitioners had been unable to remedy the conditions existing at Pennhurst in any significant way. Notes 93-95 *infra*.

80. 612 F.2d at 115; 157a.

81. 612 F.2d at 114; 156a.

recasting of the decree except on a showing of abuse of discretion."); *United States v. United States Gypsum Co.*, 340 U.S. 76, 89 (1950) (relief is "peculiarly the responsibility of the trial court"); *United States v. W.T. Grant Co.*, 345 U.S. 629, 634 (1953) (decree sustained absent showing "that there was no reasonable basis for the District Judge's decision"); *Maryland & Virginia Milk Producers Asso. v. United States*, 362 U.S. 458, 473 (1960) ("no reason to reject the judgment" where court retains "right of visitation if appropriate."); *Hills v. Gautreaux*, 425 U.S. 284, 306 (1976) (scope of remedial decree is matter of district court's "equitable discretion"); *Milliken v. Bradley*, 433 U.S. 267, 280 n. 15, 281 (1977) ("breadth," "flexibility and sensitivity required of equitable decrees.")[82]

Where Congress has by statute declared a national policy or where the public interest may be furthered, the Court's rule has been:

> Courts of equity may, and frequently do, go much further both to give and withhold relief in furtherance of the public interest.

Virginian Ry. v. Federation, 300 U.S. 515, 552 (1937). *Accord, United States v. Morgan*, 307 U.S. 183, 194 (1939); *United States v. First Nat. City Bank*, 379 U.S. 378, 383 (1965).

In the case at bar, the question is not "Did the Court of Appeals formulate the *only* acceptable relief?" or even "Were there any alternative formulations of relief possible?" The question presented is rather, "Is the relief "a reasonable exercise of power, considering both the gravity of the situation that gave rise to the orders and the

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82. Lower court's discretion in matters relating to judgments has long been noted in this Court. *Sun Cheang-Kee v. United States*, 70 U.S. 320, 326 (1865). *See Pomeroy's Lessee v. State Bank of Indiana*, 68 U.S. 592 (1863).

extent to which they intrude on other important interests?"[83]

If, settling its mandate within the range of possible acceptable choices, a court fashions an equitable decree, the relief will be upheld. *Swann v. Charlotte-Mecklenburg Board of Education*, 402 U.S. 1, 27, n.10 (1971).[84]

B. The Relief Granted is Fully within Appropriate Discretionary Limits.

Every element of relief upheld by the Court of Appeals was fully justified by the "circumstances present and the options available in each instance." *Swann*, 402 U.S. at 27 n.10. *See Milliken v. Bradley*, 433 U.S. 267, 280-281 (1977). Petitioners' contrived and vague objections are entirely misplaced.[85]

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83. The quoted test is from *Morgan v. McDonough*, 548 F.2d 28, 31 (1st Circ. 1977), the Boston schools receivership case.

84. The concept of choice inherent in "equitable discretion" has been considered in connection with institutional litigation:

> Equitable discretion is a term usually associated with the idea of judicial choice. The idea of a choice necessarily implies that there are at least two acceptable alternatives and that the court has the power to choose between them.

Special Project, *The Remedial Process in Institutional Reform Litigation*, 78 Colum. L.Rev. 784, 857 (1978) (notes omitted). *See Lemon v. Kurtzman*, 411 U.S. 192 (1973).

85. The Court of Appeals erred in reversing Judge Broderick's orders that admission to Pennhurst be closed and that the facility be replaced. Undisputed facts proved abominable conditions which every member of the Court of Appeals found illegal and proved that every person confined in the institution can and should be cared for in a continuum of less costly, more effective structured community settings. An appropriate response to the facts is to ensure that nobody unnecessarily endure Pennhurst. It was not an abuse of discretion for the trial court to so order and, therefore, the questions presented in the cross-petition, No. 79-1414, Question Presented No. 4 *supra*, should be answered affirmatively and the Court of Appeals' decision reversed in this regard.

1. *Individual determinations*

Retardation and techniques for habilitation are not afflicted by the vagaries of the "baffling field of psychiatry;"[86] determination of a retarded person's habilitative needs is accomplished through methods and procedures, and with goals, set forth by Congress. 42 U.S.C. §6000 (7) defines "developmental disability" with precision and emphasizes that habilitative services are *individually planned and coordinated*. Section 6010, in each of its parts, stresses the need for services appropriate to *the individual person* and "designed to assure the most favorable possible outcome for those served." §6010 (4). Section 6011, "Habilitation Plans," provides for periodic review of specified plans for provision of *individually* determined services. Pennsylvania law similarly guarantees *individual* consideration of habilitative needs.

This Court has held, on several occasions, that federal courts may evaluate the "nature and duration" of an individual's confinement in a mental institution. *E.g. Jackson v. Indiana*, 406 U.S. 715, 738 (1972). It is patently frivolous to suggest, as petitioners do, that habilitation issues are nonjusticiable. *O'Connor v. Donaldson*, 422 U.S. 563, 574 n. 10 (1974);[87] *Parham v. J.R.*, 442 U.S. 584, 617 (1979).

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86. *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

87. In *O'Connor* the Court held:

> O'Connor argues that, despite the jury's verdict, the Court must assume that Donaldson was receiving treatment sufficient to justify his confinement, because the adequacy of treatment is a "nonjusticiable" question that must be left to the discretion of the psychiatric profession. That argument is unpersuasive. Where "treatment" is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present. See Jackson v. Indiana, 406 U.S. 715, 32 L Ed 2d 435, 92 S.Ct. 1845.

422 U.S. at 574 n.10. *Parham v. J.R.*, 442 U.S. 584 (1979) which dealt with voluntary admission of minors, supports the *O'Connor-Jackson* rationale in requiring, "On remand, the District Court is

Careful review of the needs and condition of every resident at Pennhurst is a *sine qua non* of determining whether an improved Pennhurst or one of a variety of habilitative alternatives is appropriate to satisfy the requirements of federal and state statutes. So held the Court of Appeals:

> The state statute, like the federal statute, was focused on *individual* needs. Since the statutory rights to treatment, state and federal, vindicate the individual patient's fundamental interest in personal liberty, it is only fitting that the Commonwealth be required to undertake a case-by-case investigation into how each person's rights may best be facilitated. (Emphasis in original).

612 F.2d at 115; 157a.[88] *Milliken II* teaches that the

NOTE 87 — *(Continued)*
free to and should consider any individual claims that initial admissions did not meet the standards we have described in this opinion." 442 U.S. at 617.

88. The dissent was at one with the majority is realizing not only that Pennhurst as an institution "is not providing its residents with minimally adequate supervision and care," 612 F.2d at 129; 192a, but that, as to individuals, particularized inquiry may be necessary:

> Moreover, my rejection of less-drastic means analysis does not mean that I conceive of a "properly run institution" as a monolithic concept unrelated to the needs of particular individuals. What may be the appropriate treatment very likely will vary from person to person within the institution. The test I choose — a right to treatment rationally related to the purpose of the state-imposed restraints on liberty — applies to every individual, whether inside or outside an institution. Thus in my view, the phrase "properly run institution" means properly run as to all those confined in it. Given the current medical definition of retardation and the fact that I do not know what a properly run Pennhurst would be like, I leave for future cases the question of whether a particular individual placed in an institution free of the deplorable conditions in the record here would ever have a constitutional right to treatment in a different environment.

Id.

"remedy is to be determined by the nature and scope" of the violation, and must relate to the offensive "condition." 433 U.S. at 280, 282. Here, the violation is the failure to provide individually determined habilitation and the offensive condition is the indefensible and undefended regime at Pennhurst. The individual determination remedy is one well within the lower court's discretion.

2. *Appointment of a Master*

Petitioners assert that the Court of Appeals' order violates principles of federalism and must therefore be reversed. A cursory analysis of the history of the case discloses the recalcitrance of the petitioners, their refusal to remedy systemic violation of respondents' rights, and the absolute necessity of an order "tailored to cure" the offending condition. *See Milliken v. Bradley*, 418 U.S. 717, 738 (1974).

As the court below recites, 612 F.2d at 89-90; 150a-151a, after its finding of liability, the District Court provided respondents several opportunities to come forward with a plan to remedy the violations found by the court or to introduce evidence of relief and implementation. *Id.* The county defendants produced no plan and presented no evidence. The Commonwealth defendants resubmitted a "vague and indefinite" plan the court had rejected during the trial. 446 F.Supp. at 1325; 78a. At no time did any petitioner indicate willingness to conform its actions to the legal standards set forth by the court. *Id.* Without any enforcement tool, the respondents would have found themselves with a paper victory, confined among the horrors of Pennhurst, without hope. The Court of Appeals expressed the need for workable relief vigorously:

> It is abundantly clear that providing the 1200 Pennhurst residents with a right to habilitation in the least restrictive environment will be a complex

> and lengthy process, probably involving monitoring, dispute resolution, and development of detailed enforcement mechanisms. Were we to preclude the trial court from resorting to a master, we would help make self-fulfilling the frequently made prophecy that courts are institutionally incapable of remedying wholesale violations of legally protected rights.

612 F.2d at 111; 148a.

The Special Master in no way supplants state and local retardation authorities; the master "is to supervise all implementation efforts with the aid and assistance of all parties to the lawsuit. The defendants will thus have an opportunity to participate in the structuring of relief." 612 F.2d at 112; 151a. In shaping the activities of the Special Master, the District Court has been even more limiting than the Court of Appeals' careful language; under the implementation orders of Judge Broderick, the Commonwealth and counties are given the responsibility for services to the disabled, with the Master acting as a stopgap and the court's eyes and ears. *E.g.*, Order of April 24, 1980 (pursuant to Court of Appeals' mandate, consolidating and amending all prior orders of the District Court).[89]

In addition, because a state statute and a federal statute form the basis for the petitioners' obligation to provide habilitation, and because "[t]hese duties were known and consented to," any relevant federalism com-

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89. The use of "persons unconnected with the court to aid judges in their performance of specific judicial duties" is a proper and familiar phenomenon. *In re Peterson*, 253 U.S. 300 (1919). This Court itself uses masters in certain situations. *See Masters and Magistrates in the Federal Courts*, 88 Harv. L. Rev. 779 (1975). On "master-supervised formulation" and administration of remedies, *see* Special Project, *The Remedial Process in Institutional Reform Litigation*, 78 Colum. L. R. 784, 805-809, 836-837 (1978).

plaints are vitiated. 612 F.2d at 112; 151a. Such complaints, in fact, are considerable premature. A concrete disagreement raising federalism issues will not occur until a person is to be placed in a setting which is opposed by the state, counties or the person himself or herself. Such a placement will not occur without the opportunity to raise the issue in the District Court. There is time enough in a real case to raise and consider the federalism issue.

Respondents may yet offer "a plan that promises realistically to work, and promises realistically to work now." *Green v. County School Board*, 391 U.S. 430, 439 (1968). Barring such a plan, a federal court must exercise its broad and flexible power to effectuate a remedial decree to meet the fact situation before it. *Milliken v. Bradley*, 433 U.S. 267 (1977).

Serious and life-threatening conditions were found by the lower court to be the responsibility of state welfare department and county officials. Evaluation of the needs of respondents and development of a plan for the future are clearly remedial and not punitive, *see Milliken v. Bradley, supra*, 433 U.S. at 288, and are imperative to implementation of respondents' rights. The record conclusively demonstrates the inability of the Commonwealth to act and the failure of the counties to provide mandated services. "Judicial authority enters only where local authority defaults."[90] *See Milliken v. Bradley, supra*. A more persuasive case of such local default could hardly be imagined.[91]

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90. *Swann v. Charlotte-Mecklenburg Bd. of Education*, 402 U.S. 1, 15 (1971). In *Swann*, as here, the patient district judge urged the school board "on at least three occasions" to "come forward with an acceptable plan of its own." *Id.* at 24.

91. Respondents fail in their struggle to draw this case under the rubric of *Rizzo v. Goode*, 423 U.S. 362 (1976) and *Bell v. Wolfish*, 441 U.S. 520 (1979). In both those cases, lower courts were found to have entered orders far beyond the bounds of any cognizable rights. Here, the Court of Appeals has done nothing more than uphold a mechanism for directly implementing state and federal

3. *Implications for other states of nature of relief in Pennsylvania*

Declaration of a federal or state statutory right to habilitation in an appropriate individually determined setting threatens neither the policies nor the practices of the states.

a. Relief in this case, as in any other, is tailored to specific local history and circumstances. *Swann, supra; Milliken II, supra.* Pennsylvania presents a tragical ironic combination of historic development of extensive community services,[92] actual availability of millions of unspent dollars for such services,[93] a horrendous insti-

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NOTE 91 — *(Continued)*
statutory rights. In *Rizzo* and *Bell*, unlike this case, there was no recalcitrance by government officials in hewing their actions to the limits of the law.

Bell did not restrict judicial intervention into "deplorable conditions and draconian restrictions" which "federal courts rightly have condemned. *Id.* at 562.

92. Pennsylvania is a "leader among states" in its residential programs for the retarded, Tr. 7-4 Settle, with a "highly developed" system. Tr. 12-26 Conley. *See* Tr. 6-50, ("excellent" facilities in community for former Pennhurst residents), 6-52 to 56 Glenn; photographs 69, 71, 73, 74, 76-79, 82 and 83 at Ex. G-48 (existing community facilities). In 1965, Pennsylvania's "comprehensive mental retardation plan" became one of the first in the country and its 1966 state statute was "one of the earliest of such acts and really began to focus on alternatives to institutional care." Tr. 7-82 to 83 Dybwad. *See* Tr. 19-212 Aaronson.

93. Between $15,000,000 and $18,000,000 of $21,000,000 appropriated "for community facilities to free 960 Pennhurst residents and allow them to live in the community," Tr. 7-83 Dybwad, remained unspent at the time of the trial. Tr. 97-97 to 98 Dybwad (stipulation by defendants): PARC Ex. 60 (status report on funds); Tr. 13-136, 159 Hersh. For the years 1972 through 1975, the five county defendants returned to the state $5,600,000 in unexpended funds for community retardation services. PARC Ex. 58; Tr. 7-98 Dybwad. The cost of Pennhurst would more than cover the cost of community care for every one of its residents. Tr. 27-39 to 40 State Regional Retardation Commissioner Rice.

tution slated for elimination,[94] and a systemic inability and refusal to protect the lives of retarded people.[95] Mechanisms necessary to provide effective relief for Pennhurst residents have been melded by the lower courts into orders tailored to *this case;* no mold of universal applicability need be cast by this Court.

Implementation of the rights of retarded persons in other states requires courts to examine local law, the status and history of both institutional and community resources and current efforts of defendant officials to fulfill their responsibilities. While the ultimate requirement of the Bill of Rights Act — individually determined habilitation in an appropriate least restrictive setting — may not be compromised, "there is obviously no one plan that will do the job in every case. The matter must be assessed in light of the circumstances present and the options available in each instance." *Swann, supra,* 402

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94. The State Regional Retardation Commissioner testified that the state's intention is that "sometime in 1983 Pennhurst would be empty," under a five-year plan. Tr. 28-48, 101 Rice; 1-183, 185 Roos State officials believe that no person need be in the institution. Youngberg Dep. 102; Tr. 22-171 to 172 Youngberg; Tr. 22-77 Foster; Foster Dep. 63; Rice Dep. at 180-181; Tr. 26-22 Rice. The experts retained by the state agree. Tr. 14-73 Thurman; Tr. 14-21 Walker.

95. Reiterated instances of the defendants' recalcitrance cover the record. Although as early as 1965 Pennsylvania knew what must be done, virtually nothing happened despite extensive plans, studies, reports, and blueprints. *E.g.*, Tr. 7-82 to 93 Dybwad; 1-174 Roos; 13-159 to 163 Hersh; PARC Ex. 18 through 27; 59, 60; Plaintiffs' Ex. P-2, P-16, P-17. The $21,000,000 intended in 1971 to move 960 people from Pennhurst had benefited only 40 people at the time of trial. Tr. 28-19 to 20 Rice. State defendants do not monitor or work with the counties and the counties fail to plan properly or abide by state law. Tr. 12-16 to 19, 42 to 43 Conley; 13-134 to 136 Hersh; 18-116 to 18-132 Hindman; 28-11 to 13, 16 Rice. This "confusion," of course, causes harm to the plaintiffs; for example, Pennhurst recommended community care for Nancy Beth Bowman, but nothing was done. Tr. 13-91 Bowman.

U.S. 1, 27 n. 10, quoting *Green v. County School Board*, 391 U.S. 430, 439 (1968). "*Actio quaelibet it sua via.* (citations omitted). Every action proceeds in its own peculiar course." Henig, *Maxims* in *Branch's Principia Legis et Aequitatis* at 12 (1824).

b. Every one of the fifty states has, by statute, provided for some or all of the rights and policies recognized by the lower courts in the case at bar.

As the overlapping categories in the Table on the following pages summarizes, 26 states establish a right to habilitation or treatment, 17 establish a state responsibility or policy to provide habilitation or treatment, 14 explicitly require services in the least restrictive environment, 8 explicitly require an individualized plan and 5 either name specific facilities to provide habilitation or treatment or grant authority to enforce laws relating to habilitation or treatment in community centers.[96]

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96. The statutes from which the table is drawn are ALA. CODE, tit. 22, §§22-50-11, 22-52-51 (1975); 1978 ALASKA SESS. LAWS ch. 165, §1; ARIZ. REV. STAT. ANN. §36-551.01 (West. Supp. 1979-80); ARK. STAT. ANN., tit. 59, ch. 10, §§59-1002(i), 59-1009(a)(1971); CAL. WELF. & INST. CODE §4502 (West Supp. 1980); COLO. REV. STAT., tit. 27, §27-10.5-115 (Supp. 1973); CONN. GEN. STAT. ANN., tit. 19, §19-575a (West 1958); DEL. CODE, tit. 16, §§5502-5507; tit. 9, §2612, as amended by S.B. No. 130th Gen. Ass. (Signed July 10, 1980); D.C. CODE, Bill 2-108, "Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978," §§102, 103; FLA. STAT. ANN., tit. 28, §394.459 (West Supp. 1980); GA. CODE ANN. §§88-2502 (Supp. 1979); HAWAII REV. STAT., tit. 19, §§33 E-1, E-2; IDAHO CODE §56-238; ILL. ANN. STAT., ch. 91½, §2-102(a) (Supp. 1980-81); IND. CODE ANN. §16-14-1.6-2 (Supp. 1979); IOWA CODE ANN., tit. 21, §222.1 (West Supp. 1980-81); KAN. STAT. ANN. §75-3307b(a) (Supp. 1979); KY. REV. STAT. ANN., tit. 17, §202.267 (1969); LA. REV. STAT. ANN., tit. 40, §2013.50 (West 1977); ME. REV. STAT. ANN., tit. 34, ch. 221, §2601 (1964); MD. ANN. CODE, art. 59A, §8A (1979); MASS. ANN. LAWS, ch. 123, §2 (1972); MICH. COMP. LAWS ANN. §330.116; MISS. CODE ANN. §41-19-81 (1973); MO. ANN. STAT., tit. 12, §202-900 (Supp. 1980); MONT. CODE ANN. §53-20-142 (1979); NEB. REV. STAT., ch. 83, art.

An increasing number of states have responded to federal developments by enacting laws explicitly serving "developmentally disabled" people (*e.g.*, Arizona, California, Hawaii, Indiana, New Hampshire, New Jersey, New Mexico, Wisconsin and Wyoming). Some states emphasize the goal of services for a person as "an early return to his community" (Florida) and others echo the refrain that services should be "as close as possible to the patterns and norms of the mainstream of society." (Maine, for example). The states do not restrict these rights to the least disabled, but rather stress that all are entitled. *E.g.*, Delaware's right to habilitation "no matter how severe their disability may be."

c. States' legitimate interest in adopting and pursuing their own strategies for compliance with the Developmentally Disabled Assistance and Bill of Rights Act are supported, not undermined, by a correct construction of the opinion of the Court of Appeals. They would not be required to "easily" and "immediately deinstitutionalize" without regard to the context in

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NOTE 96 — *(Continued)*
1(h), §83-1, 141 (1976), as amended, 1979 Neb. Laws, LB187, §253; NEV. REV. STAT., tit. 39, §443.484 (1979); N.H. REV. STAT. ANN., tit. 10, §171A-13 (Supp. 1979); N.J. STAT. ANN. §30:6D-9; N.M. STAT. ANN., §43-1-8 (1978); N.Y. MENTAL HYG. LAW, tit. C, art. 13, §13.01 (1978); N.C. GEN. STAT., §122-55.6 (1974); N.D. CENT. CODE, §25-16-10, 25-17-03 (1970); OHIO REV. CODE ANN., tit. 51, §5123.85 (1974); OKLA. STAT. ANN., tit. 43A, ch. 1, §§50, 3, 93 (West Supp. 1979); OR. REV. STAT., tit. 35, §427.010 (1977); R.I. GEN. LAWS §40.1-22-6, §§40.1-21-4, 40.1-22-6, 11, 40.1-1-10.1 (Supp. 1979); S.C. CODE §44-21-20 (1976); S.D. CODIFIED LAWS ANN., §27B-8-11; TENN. CODE ANN. §33-501 (1977); TEX. MENTAL HEALTH CODE ANN., tit. 92, art. 5547-300, subch. C, §§7, 11 (1980); UTAH CODE ANN. §64-8-6 (1953); VT. STAT. ANN., tit. 33, ch. 49, §3613 (1979); VA. CODE ANN. §37.1-194 (Supp. 1980); WASH. REV. CODE ANN. §71.20.010 (1975); W. VA. CODE §§27-5-9, 27-5-4(j), 27-2-3 (1980); WIS. STAT. ANN., tit. 7, §51.61 (West Supp. 1979-80); WYO. STAT. ANN. §35-1-612 (Supp. 1979).

ALL STATES' STATUTORY PROVISIONS REGARDING RIGHTS TO HABILITATION AND TREATMENT FOR THE MENTALLY DISABLED*

States	Statute establishes a right to habilitation or treatment	Statute establishes state responsibility or policy to provide habilitation or treatment	Statute explicitly requires services in least restrictive environment	Statute explicitly requires an individualized plan	Other statutory requirements
Alabama		X			
Alaska	X				
Arizona			X		
Arkansas		X			
California	X				
Colorado	X				
Connecticut	X				
Delaware	X				
District of Columbia	X		X	X	
Florida	X		X		
Georgia		X			
Hawaii		X			
Idaho	X				
Illinois	X		X	X	
Indiana	X				
Iowa					X[2]
Kansas					X[4]
Kentucky	X				
Louisiana					X[2]
Maine	X		X		
Maryland		X		X	
Massachusetts	X	X			
Michigan		X			
Minnesota		X			X[1]
Mississippi					X[1]
Missouri		X	X		
Montana	X				

ALL STATES' STATUTORY PROVISIONS REGARDING RIGHTS TO HABILITATION AND TREATMENT FOR THE MENTALLY DISABLED*

States	Statute establishes a right to habilitation or treatment	Statute establishes state responsibility or policy to provide habilitation or treatment	Statute explicitly requires services in least restrictive environment	Statute explicitly requires an individualized plan	Other statutory requirements
Nebraska		X			X[1]
Nevada	X				
New Hampshire	X				
New Jersey	X		X		
New Mexico	X		X	X	
New York		X			X[1]
North Carolina	X			X	
North Dakota		X			
Ohio	X			X	
Oklahoma		X	X		
Oregon					X[2]
Rhode Island			X		
South Carolina		X	X		X[1]
South Dakota	X			X	
Tennessee		X			
Texas	X		X		
Utah					X[2]
Vermont	X				
Virginia		X			
Washington		X			
West Virginia	X		X	X	X[1]
Wisconsin	X		X		
Wyoming	X				

This chart includes only statutes; no regulations or published administrative policies have been considered.

1. Excluding Pennsylvania.
2. Statute names specific facilities to provide habilitation or treatment.
3. Statute grants state authority to enforce laws relating to habilitation or treatment in community centers.
4. The state shall coordinate services.

which each operates.[97] Rather, only where local authorities default, as in Pennsylvania, will courts be compelled to fill the vacuum.

The Court of Appeals' "programs were not, and as a practical matter could not be, intended to wipe the slate clean by one bold stroke. . . ." *Milliken v. Bradley*, 433 U.S. 267, 290 n.22 (1977). Nor did Congress mandate the impossible. A states' effective action to provide individually appropriate habilitation under §6010 of the Act cannot be completed in a day, but it can be undertaken.

CONCLUSION

For the above reasons, the Court of Appeals should be directed to fully affirm the District Court's orders, including the requirement that the large isolated and irredeemable institution called Pennhurst be replaced through the existing Pennsylvania continuum of structured community residential and support services. In the alternative, the decision of the Court of Appeals should be affirmed, unless certiorari is dismissed as improvidently granted.

As a co-sponsor of the 1978 amendments to the Bill of Rights Act declared:

> The time has been long coming that our handicapped citizens are given the opportunities which every American citizen has the right to enjoy. It is

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97. Amici Curiae Brief for Illinois, *et al.*, at 38-39. These *amici* states "do not oppose deinstitutionalization where appropriate" and are implementing "comprehensive deinstitutionalization plans concerning the majority of individuals now receiving care in public institutions for the mentally retarded." *Id.* at 1-2. *See* Brief of Connecticut as Amicus Curiae at 1-2. There is no disagreement with the wisdom of the Court of Appeals' approach but rather a divergence of views as to the appropriate source of the impetus for deinstitutionalization.

> our intention not only to help those in need of rehabilitation but to help the many severely handicapped to live a more independent existence and not to be confined to a cell in an institution.

124 Cong. Rec. S.15569 (Sen. Hatch).[98] "As lawmakers and as citizens we must help protect the rights of these severely handicapped persons." 124 Cong. Rec. S.15548 (Sen. Randolph).

Respectfully submitted,

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Penelope A. Boyd

Counsel for Respondents
*Terri Lee Halderman, et al.**

October 20, 1980

98.

> It is morally wrong, when an affluent and supposedly compassionate nation allows thousands upon thousands of people to be shut away, forgotten, and left simply to exist. There is a great need for a variety of continuing services for severely handicapped persons, who have much to contribute — if they have the necessary support services.

124. Cong. Rec. S.15657 (Sen. Humphrey).

*Counsel gratefully acknowledge the support and assistance of Virginia Raymond, Joseph P. Green, Jr., Martha Boston, Mary Lovitz and Carol Robinson.

APPENDIX

Narrative Summary of the Record

The record in this case is an extraordinary documentation of every facet of the institution called Pennhurst. Even the detailed summary below cannot begin to tell it all.

Areas considered include an introduction to the institution and the physical environment,[1] injuries and physical abuse,[2] psychological abuse and absence of program,[3] physical restraints, chemical restraints and seclusion,[4] regression,[5] potential for improvement of the institution,[6] and community services.[7]

A. The Institution

The effect of Pennhurst State School and Hospital on its residents, mentally retarded people, is the focal point of this action. Pennhurst was established on the

1. Pages A1-A7.
2. Pages A9-A12.
3. Pages A12-A15.
4. Pages A15-A18.
5. Pages A18-A20.
6. Pages A20-A22.
7. Pages A22-A26.

outskirts of Spring City, Pennsylvania, in 1908 as the Eastern Pennsylvania School for the Feeble-Minded and Epileptic.[8] Its purpose then and its purpose today is to provide training for mentally retarded citizens to enable them to return to our society and function as productive members of it.[9] Throughout its history, Pennhurst has been unable to fulfill this intention.[10] Instead, it has continually visited inexorable physical and psychological damage on those it was established to assist, increasing the helplessness of persons who by virtue of their handicap are least able to resist an inflexible system and most likely to suffer from it.

Retardation is neither a disease nor an illness.[11] It is a handicap which manifests itself in impaired intellectual ability and, in some cases, problems in adaptive be-

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8. Act 424, Laws of Pennsylvania (May 15, 1903), Act 42, Laws of Pennsylvania (April 4, 1907).

9. Mental Health and Mental Retardation Act of 1966, 50 Pa. Stat. Ann. §§4101 *et seq;* "care and training," Act 424; "maintenance and training," Act 42, *supra* note 8; Ex. P-1, P-2, P-6.

10. Pennhurst has been successful in achieving another explicit purpose of state legislation, "segregation" of the retarded at the facility. Act of June 12, 1913, 32 Laws of Pennsylvania 494.

11. Mental retardation and mental illness have no similarity to one another; they are "two entirely different conditions."

> Mental retardation refers primarily to a deficit in intellectual development and social adaptation; whereas mental illness refers to a disorder of thinking, emotions and behavior.
>
> Mental retardation occurs usually either prior to, at, or shortly following birth; whereas mental illness can occur at any time in life and often the onset is during adulthood.
>
> Mental retardation is primarily an educational problem; mental illness is primarily a psychiatric problem.
>
> Whereas mental retardation is essentially irreversible, that is, although it can be improved, there is at this stage of our knowledge no cure; mental illness is often reversible and curable.

Tr. 1-87 to 88 Roos; 446 F.Supp. at 1298; 10a; Tr. 2-2 to 2-12 Clements.

havior.[12] While mental retardation cannot be cured in the conventional sense, its effects can be overcome through habilitation, the process by which retarded individuals are aided in acquiring and maintaining those life skills which enable them to cope more effectively with their environments and raise their level of physical, mental, and social efficiency.[13] Habilitation requires normalization of the individual's living situation because where culturally valued means are employed, retarded people are enabled to live valued lives and they respond in a fashion which minimizes the limitations of their conditions.[14] "The principles of normalization have been accepted by the administration of Pennhurst and by the Department of Public Welfare, which is responsible

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12. "Mental retardation is essentially a problem of learning, a defect particularly of the individual's ability to think abstractly, to exercise judgments, to solve problems, and to retain information. Tr. 1-85 Roos; 6-94 to 95 Settle; 446 F.Supp. at 1298; 10a; Tr. 2-13 Clements.

13. Tr. 1-96 to 1-97 Roos; 5-186 Glenn; 446 F.Supp., at 1298; 10a. Habilitation is "A generic term we use to refer to the many specific activities designed to foster maximum development of the individual. Included in the term are various approaches to education, the development of social and intellectual skills, the development of pre-vocational and vocational skills, and related types of activities." Tr. 1-95 to 96 Roos. It is implementation of the developmental model of mental retardation. "By [the developmental model] we mean essentially that retarded individuals should be approached with the assumption that they are capable of growth, of development, of learning; that the environment which we provide for them has a major impact in determination of the rate of this development, indeed, that the human organism is highly plastic and is in continued interchange with our environment. Tr. 1-105 to 106 Roos.

"[W]ith proper habilitation, the level of functioning of every retarded person may be improved" and people "may be removed from the ranks of the retarded." 446 F.Supp. at 1298; 10a; Tr. 2-7 Clements.

14. Tr. 1-106 Roos; 5-88 Girardeau; 5-186 to 187 Glenn; 7-120 Hirst. "Normalization" is a technical word of art which encom-

for the administration of programs in the five county area. . . ." 446 F.Supp. at 1311; 42a (citations to record omitted).

Pennhurst is not providing, nor has it provided, habilitation or a normalized environment to its residents.[15] They have had only the opportunity to learn self-defense and survival techniques necessary to a continued existence in an institution.

B. The Physical Environment at Pennhurst

The District Court found that "the physical environment is hazardous to the residents, both physically and psychologically." 446 F.Supp. at 1308. This finding was not made lightly, but rather was based on consideration of the testimony of eighty witnesses, who included thirteen experts on mental retardation, nine parents of retarded persons who lived at Pennhurst, three former residents of Pennhurst, thirty-nine employees of Pennhurst, and two officials of the Commonwealth of Pennsylvania. Voluminous documentary evidence, including photographs of Pennhurst, were also introduced at the trial before Judge Raymond J. Broderick.

NOTE 14 — *(Continued)*

passes the techniques and goals of habilitation. *See* Wolfensberger, "The Definition of Normalization: Update, Problems, Disagreements, and Misunderstandings," in *Normalization, Social Integration and Community Alternatives* (Flynn & Nitsch eds. 1980). Normalization means that the "environment should be designed to increase the complexity of the behavior of the developing individual to increase his human qualities as these are defined by the world in which we live.*** [U]nfortunately we have tended to foster and generate deviancy by treating people as if they were different by isolating them and segregating them from society. Tr. 1-106 to 107 Roos.

15. 446 F.Supp. at 1318; 58a. "[F]or the retarded class members as a whole, Pennhurst cannot be an appropriate setting in which to provide habilitation." 612 F.2d at 114; 156a.

Currently, Pennhurst does not meet minimum professional or governmental standards set for such an institution for mentally retarded persons.[16] As the Acting Medical Director of the institution admitted at the trial, Pennhurst's ". . . physical plant itself would not measure up to any standards" Tr. 19-185, Hedson. Many of its buildings have been in use since its founding in 1908 and the deteriorating structures are in constant need of repair.[17] Often the buildings are fire traps.[18]

Concrete and tile are the primary components of the physical environment at Pennhurst.[19] Petitioners' characterization of the living quarters which house the majority of residents as "larger older dormitory settings" distorts the daily living conditions of Pennhurst residents. Brief for Petitioners at 2 n.2. Residents live in "totally intolerable conditions." Tr. 1-175, Roos. The buildings at the institution are subdivided into wards, each ward consisting of, at least, a sleeping area, a dayroom and a bathroom, none of which are constructed or used in a fashion which might be minimally consistent with the common perception of a dormitory.[20]

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16. *E.g.*, 446 F.Supp. at 1302, 1308; 24a, 34a. Tr. 19-185 Hedson; 7-54 Dybwad ("emergency" conditions); 1-172 to 173 Roos ("totally unsuitable buildings"); 1-110 to 115 Roos (professional and governmental "minimum standards" not met).

17. Tr. 8-127 Hirst; 2-159 Taub; Ex. G-42, G-46.

18. The Security Office at Pennhurst is its own fire department from 3:00 p.m. to 7:00 a.m. Ruddick Deposition at 7, 38. Security personnel have extinguished minor fires "numerous times." *Id.* at 38-39. Tr. 9-145 Sobetsky; 6-146 to 150 Settle.

19. *E.g.*, Clements N.T. 2-54, 2-57, U.S. Ex. 48, Photos 21, 26.

20. As one former resident of Pennhurst described his former home, "It looks like a darn big place and it has a gang of boys. They sleep together and all." Tr. 8-5 Troester. Mr. Troester entered Pennhurst at the age of seven. He left the institution for the community at the age of 18, and is now employed. His story is discussed *infra* at 28. Another former resident explained, "It was like one big room with forty in them." Tr. 8-22 Hill.

The mother of two named plaintiffs described their ward as "the most awful place I have ever seen in my life." Tr. 13-19 Taylor. She was asked:

> Q. What did the ward look like physically?
>
> A. Physically, the floors were concrete. They were cracked, full of holes.
>
> The place smelled of urine and feces.
>
> The holes in the concrete were filled with filthy water and the children looked like prisoners.[21]

It is "a stultifying and essentially a dehumanizing environment." Tr. 7-52 Dybwad.

In sleeping areas on the wards at Pennhurst, beds are found row upon row. One ward was described as having three rows of four beds with about three or four feet of space separating them; a five foot high tile wall separates the rows of beds.[22] Sleeping areas are often insufficiently furnished, and generally lack any provisions for individual privacy, much less sufficient pillows, bedspreads or decoration.[23]

Dayrooms at Pennhurst, where the bulk of the residents' time is spent, often have no furniture at all, although some have a few chairs or tables and a television, and the rooms are poorly lighted.[24] The hard surfaces

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21. Tr. 13-19 Taylor. *See* Tr. 12-82 Caranfa (ward of plaintiff Sorotos a "big room with a broken cement floor"); 1-132 Roos ("a very barren place . . . just bare floor and bare wall"); 1-171 Roos describing Photo 54 in Ex. G-48; ("just the bare floor and walls, and that is a resident almost nude lying on the bare floor"); 8-109 Hirst; 7-53 Dybwad ("an ugly place," "inhuman dimensions"); 2-152 Taub ("snakepit" where plaintiff lived); 4-70 Lancaster-Gaye.

22. Nagle Dep. at 16-18.

23. Photos 29, 30, and 56 at Ex. G-48; Tr. 1-149 to 150 Roos; 2-54 to 55, 93 to 94 Clements; 19-46 Pirmann; Smith Dept. at 43-44; Nagle Dep. at 16-18.

24. *E.g.*, Photo 54, 102 and 103 at Ex. G-48; Tr. 1-171 Roos, 6-149 Settle; Smith Dep. at 43-44; Nagle Dep. at 5-10; notes 19-21 *supra*.

and lack of furnishing amplify the continuous "blaring" noise at the institution.[25]

The shower and bathing areas on the wards of Pennhurst are as dehumanizing as the sleeping areas and dayrooms. Consistent with the rest of the ward environment, they are totally bereft of provisions for privacy; like the beds, the toilets are lined row upon row, without doors or partitions to grant even minimal privacy.[26] Toilets lack seats "universally" and toilet paper.[27] The hard surfaces of the bathroom floors, already dangerous because slippery, are made even more so so due to the practice of covering them with wet sheets.[28] Bathing areas have no soap or towels.[29] These are "conditions which violate the very basic rules of hygiene." Tr. 1-158 Roos.

Pervasive filth in all areas of the wards compounds the problems of barren and dehumanizing design and

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25. Tr. 1-150 Roos; 6-149 Settle; 5-98 Girardeau. "Moreover, the noise level is often so high that many residents simply stop speaking. (Clements, N.T. 2-59)." 446 F.Supp. at 1308; 35a.

26. Tr. 1-149, 158, 169 to 170 Roos (no privacy, dirt, "feces on the wall and the floor"); 2-40 Clements; Troester 8-6 to 7; Photos 5, 39, 105, 106 at Ex. G-48; Barton Dept. at 26.

27. Tr. 1-158 Roos; 5-96 Girardeau; Nagle Dep. at 26; 2-160 Taub; 3-142 Lowrie.

28. Photo 39, 42, 43 and 44 in Ex. G-48; Tr. 2-42 to 45 Clements; 446 F.Supp. at 1309; 37a (plaintiff DiNolfi lost an eye after slipping in shower).

29. Photo 7 in Ex. G-48; Tr. 2-41 to 43 Clements; 1-149 Roos. During the mass showering in "wide open" areas, Tr. 8-6 to 7 Troester, residents have been "squirted down with a big hose" while "screaming with fear." Tr. 12-82 to 83 Caranfa (regarding plaintiff Sorotos). For morning washing, a Pennhurst employee explained, "We might take a wet rag across legs and arms." Nagle Dep. at 40. The absence of soap, towels and adequate bathing procedures have serious consequences for treatment. Tr. 2-41 to 43, 45 Clements. In addition, physically dangerous bathing practices are engaged in. Tr. 2-38 Clements (describing photo 1 in Ex. G-48).

non-existence of basic necessities of hygiene. Excrement and urine are often found on the floors of wards; bathrooms contain unflushed toilets, excrement on toilet seats (when seats are available at all), walls and floors.[30] One expert witness "observed excrement, urine, dirty mops strewn about, [and] pools of water on the floor."[31] Urine and feces remain on ward floors, in residents' beds and on bodies for lengthy periods of time.[32]

As might be expected, the ubiquitous filth at Pennhurst causes interminable odor as well as infestation of vermin. Roaches permeate the facility. Smith Dep. at 38, 47. Flies are commonly observed crawling on the bodies of residents. Tr. 18-69 Pool.[33] Residents suffer from epidemics of pinworms and various infectious diseases.[34]

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30. Tr. 1-158, 160, Roos; Smith Dep. at 41; Photo 50 at Ex. G-48. Seclusion rooms have feces on ceilings and walls. Tr. 1-134 Roos; 4-179 to 190 Lowrie; Ex. P-6 (Pennhurst staff committee report).

31. Tr. 1-160 Roos.

32. "There was frequently urine and feces on the floor, under their fingernails, in their hair and still is" Tr. 12-63 Caranfa (re plaintiff Sorotos); 2-161 to 162 (defecation in beds); Smith Dep. at 41 (floors),

33. One witness testified:

> There was one time when there was a baby lying on the floor and the flies were in her mouth and nose and I picked them out and asked the girl who worked at Pennhurst, Dorothy, in charge of the ward, to do something about it.
>
> And she said, "Well, what do you think I can do."
>
> And I came downstairs and complained to Norma Beard and I said they should have the baby in a crib with mosquito netting over the crib.
>
> It was summer and there were a lot of flies drawn by all the urine and feces all over the place.

Tr. 12-80 to 81 Caranfa.

34. Tr. 16-193 Conley; Hedson Dep. at 1222.

C. Injuries and Physical Abuse

Accidents on slippery floors and diseases are far from the only harms inflicted by Pennhurst on its residents. Rather, the catalogue of hazards is as long as it is shocking, as is evidenced by a report of just one month at the institution. In January of 1977, for example, 833 residents of Pennhurst suffered minor injuries and 25 residents suffered major injuries.[35] After reviewing this summary of injuries to residents, one expert characterized the document as a "battlefield report" and concluded that "[i]t appears that it is physically hazardous for the residents to be in the environment."[36] The number of injuries at Pennhurst is "fairly constant," a Pennhurst official testified.[37]

Each named plaintiff sustained serious injury while in the institution. 446 F.Supp. at 1309-1310; 36a-40a. Larry Taylor "was beaten about the head and face so badly he was unrecognizable. You couldn't see eyes, nose and mouth. I mean he was totally beyond recognition." Tr. 13-30 Taylor; letter to superintendent 13-64 to 65. Both Larry and Kenneth Taylors' "heads have been cracked open so often that there are spots on their heads where they will never grow hair." Tr. 13-23 Taylor. Nancy Beth Bowman "was bruised constantly, marked, black eyes" so that she "will be scarred for the rest of her life." Tr. 13-72, 75 to 77, 94 Bowman. Pennhurst classi-

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35. Ex. G-15; Youngberg Dep. at 78-84; Tr. 158, 163, 164 to 169 Roos. Very few bones in residents' bodies have not been broken at one time or another. *See* Tr. 15-130 Girardeau; Ex. G-18 (fingers and toes); Hedson Dep. at 116 (ribs); 1-165 Roos (broken arm not discovered for 24 hours); Hedson Dep. at 101 (arm); 7-137 Hirst (pelvis); Mathew Dep. at 81 (spine). *See* Ex. G-14 (Pennhurst Accidents and Injuries Committee Study of Fracture Records), described at Tr. 7-132 to 137 Hirst.

36. Tr. 1-163 Roos. *See* 1-164 to 169 Roos.

37. Tr. 22-40 to 41 Foster. Experts retained by the defendants agreed that the injuries were preventable. Tr. 13-154 Hersh.

fied serious injuries as "minor,"[38] including many of those observed every week for seven years (except for four occasions) on plaintiff Sorotos.[39]

Terri Lee Halderman sustained one of her forty injuries when, despite staff's knowledge of Ms. Halderman's need for supervision, she was permitted to walk around her living unit at four in the morning in a camisole (straightjacket) and a helmet. She was found lying on the floor two hours later bleeding profusely from the mouth. An aide sought and was granted permission to pull from Halderman's mouth what appeared to be a tooth; the material was later found to be part of the plaintiff's jaw, broken in the fall.[40]

Lack of supervision of residents has often caused injury and death to persons confined at Pennhurst.[41] Residents have drowned, both in bathtubs at Pennhurst and in the Schuylkill River, which flows through the grounds of the institution.[42] Often there are "missing residents" who are off the ward without staff knowledge or supervision. Ruddick Dep. at 28-30.

The design of the living units at Pennhurst exacerbates the inadequacy of staffing, contributing to unsupervised activity and hence the frequency of accidents. One of the factors contributing to Ms. Halderman's jaw fracture was that the nature of the ward design there and on other units provides blind

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38. ". . . a bite, the skin is broken in maybe six or eight places and there are scabs formed and the bruises last two weeks, you couldn't classify it as a minor bite." Tr. 12-89 Caranfa. *Accord*, Tr. 13-29 Taylor.

39. 446 F.Supp. at 1309-1310; 38a. For injuries to other plaintiffs, *see, e.g.*, Tr. 9-151 to 153 Sobetsky; Tr. 9-11 Heinsicker.

40. Tr. 8-68 to 72 Hirst. Pennhurst staff were found by a special investigating committee to have acted improperly. *Id.* Recommended policy changes were not implemented. *Id.* at 88-71.

41. Hedson Dep. at 90, 96-98; Ex. G-22, P-62.

42. *Id.*, Tr. 7-164 Roos. After several deaths, a fence was built to prevent access to the river. Residents now simply climb over it. Ruddick Dep. at 33-34.

spots that made it very difficult for the aides to supervise all of the people all of the time.[43]

Abuse of residents by the staff has been an ongoing fact of life at Pennhurst, inevitable in an overcrowded and understaffed institution. Reported incidents of abuse[44] include the eyewitnessed rape of a resident by a direct care worker,[45] beating of residents with sets of keys and shackle belts,[46] and an aide's unprovoked tossing of a small, physically handicapped child across a room. In the last instance, after the child landed on his stomach on the cement floor of his ward, the aide approached him and slapped him across the face.[47] Plaintiff Bowman's family was not told of several incidents of physical abuse by staff of their child. Tr. 13-83 Bowman.[48]

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43. Tr. 8-72, 108 Hirst; 2-60 to 62 Clements. At the time of the jaw fracture, Ms. Halderman was living in a new Pennhurst building, built in the early 1970s, called New Horizons. It was described by one expert as follows: "You would never think of human beings living there. You might store things in such a building." Tr. 7-56 Dybwad. Pennhurst staff felt it was "no place for habilitation, for people to live." Tr. 8-109, 119 Hirst.

44. Abuse is not effectively monitored. Tr. 1-144 to 146 Roos.

45. Ex. G-37; Tr. 1-167 Roos; Ruddick Dep. at 17-23.

46. Ex. G-36, G-25; Tr. 1-167 to 168 Roos; 13-83 Bowman.

47. Tr. 3-113 Ruddick; Ruddick Dep. at 24-27.

48. Former residents of Pennhurst described being "slapped around" and beaten by staff, "some with their fists." Tr. 8-32 Hill; 8-34 Vaughn. On a visit to plaintiff George Sorotos, his foster mother witnessed a child thrown five or six feet through the air:

> While I was feeding Georgie the aide was slapping several different patients about the arms and shoulders and then she took one child by the back of the neck and held open the swinging door with one hand and threw the child through and he landed on all fours in the other room.

Tr. 12-79 Caranfa. More than 3,500 painful electric shocks, causing burns on his buttocks, were administered to a resident in a program approved by the Secretary of Public Welfare. Tr. 5-31 to 5-35 Lowrie; 8-102 to 103 Hirst (the "haphazard activity . . . did not work" to aid the resident); Depositions of Lowrie and Brody. The veteran head of the Psychology Department regarded the treatment as "inhumane and torturous." Tr. 8-103 Hirst.

On his tour of the institution, an expert who testified at the trial witnessed one resident severely beating another while the scene was casually observed by a staff member. "The employee was sitting there watching," because, said the employee, "that's not in my job description." Tr. 2-60 Clements.

D. Psychological Abuse and Absence of Program and Activity

In addition to blatant forms of dehumanization, Pennhurst residents are subjected to an inherently "almost totally impersonal" setting. 446 F.Supp. at 1303. Pennhurst residents live out their lives as a group, engaging in "life maintenance activities" timed for the convenience of staff. Residents are awakened between 5:30 and 6:00 a.m. and are "toileted," showered and dressed, assembly line fashion, in bathrooms containing open rows of toilets and group showers.[49]

Meals are a health hazard for residents. At special risk are those who are fed by staff who use improper feeding techniques, such as feeding individuals while they are lying down or by raking a spoonful of food across the upper teeth, or by feeding people too rapidly. Tr. 1-159 Roos. Thus, the danger of the resident literally inhaling his food is significantly increased and can lead to death by aspiration, asphyxiation, or aspiration pneumonia. *Id.*; Tr. 2-66 Clements. Those able to feed them-

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49. *Supra* notes 26-32; Barton Dep. at 26: Klick Dep. at 140; Tr. 1-149, 160 Roos; 2-40 Clements; 5-96 Girardeau; photos 5, 39, 105, 106 at Ex. G-48. Plaintiffs are often nude, dressed in underwear, or ill-fitting institutional clothes and without shoes or socks. Tr. 1-149 Roos; 12-81 to 83, 115 Caranfa; 13-23 Taylor; 13-80 Bowman. "It was ghastly. Here was this little seven year old boy and all these naked men milling around, screaming, swearing. He was terrified and, of course, I was heartbroken. Tr. 12-61 to 62 Caranfa.

selves are subjected to thefts of food by other residents, making nutritional planning impossible.[50]

Life at Pennhurst is a continuum of inactivity and idleness.[51] An expert said:

> This is what I described as enforced idleness. These individuals are simply vegetating and there seems to be no systematic activity.[52]

Records selected by Pennhurst staff for expert witnesses confirm the inactivity, *e.g.*, tr. 2-77 to 80 Clements, as do government surveys. Tr. 18-83 Pool. Parents of plaintiffs saw

> . . . zombies, people walking around like that in an enclosure, all in straitjackets, and walking with the arms tied up.

Tr. 2-151 Taub. And,

> The toys were in the cage and they weren't allowed to have them out. I never saw a toy played with ever.

Tr. 12-63 Caranfa.

The majority of Pennhurst residents do not receive sufficient programming by minimally acceptable professional standards according to superintendent and his superiors.[53] For example, in one Pennhurst unit residents

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50. Tr. 2-71 to 72 Clements; photos 36 and 37 at Ex. G-48. Lack of nourishment is likely. *E.g.*, Tr. 1-159 Roos. On many wards residents must eat with their fingers or use spoons, the only utensil provided them. Tr. 1-159 Roos.

51. Tr. 1-120 to 122 Roos; 2-57, 77 Clements; 5-98 Girardeau; 6-149 Settle; 14-61 Thurman (expert retained by defendants); photos 8, 14, 21, 23, 26, 31, 33, 52, 55, 56, 103 at Ex. G-48. "The individuals are simply sitting there whiling away their lives."

52. Tr. 1-172 Roos.

53. Tr. 1-119 Roos; 27-72, 77 to 78 Rice; Dep. of Rice at 179, 180.

have no programs to teach them handwashing, self-feeding or toothbrushing although they are in need of these skills.[54] Residents receive only 1½ hours of programmed activities weekdays (none on weekends), including non-beneficial activities such as television. 446 F.Supp. at 1304; 24 a.[55] Programs are "almost non-existent." Tr. 2-36, 76 Clements; 2-153 Taub (plaintiff Taub); 13-23, 37 to 38 Taylor (plaintiffs Taylor).

Residents in need of specialized programs do not receive them. The head of the Psychology Department testified that "hundreds" of residents needing psychological services were not receiving them, creating "a crippling situation."[56] Long waiting lists exist for every program at the institution.[57] For example, the Speech and Hearing Department accomodates one-sixth of the residents needing such services; physical therapy is given to less than half the people requiring it; most people at Pennhurst receive no recreation or occupational therapy.[58]

The institution encourages the development or increase of behavior problems among the residents; residents engage in self-stimulating behavior ranging from rocking to self-injury and aggressive actions toward others, to relieve the interminable boredom which permeates their lives at Pennhurst.[59] These behavior problems "are symptomatic of the institution." Tr. 8-107 Hirst; 2-83 to 84 Clements; plaintiff Bowman, for example, learned to bite others at Pennhurst. Tr. 13-71 Bowman.

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54. Nagle Dep. at 25, 36, 41.

55. Six hours per day is minimally adequate, Tr. 1-120 Roos, if done in small groups in specific training activities. *Id.* at 1-123.

56. Tr. 7-106, 107 Hirst.

57. Foster Dep. at 42; Tr. 1-153 to 154 Roos.

58. Foster Dep. at 42, 46; Rossi Dep. at 22; 446 F.Supp. at 1304-1305; 24a-26a.

59. *E.g.*, Tr. 1-96 to 98 Roos; 5-112 Girardeau.

There are no programs in use to decrease such behavior.[60]

E. Physical Restraints, Chemical Restraints and Seclusion

While adequate programming could reduce or eliminate these behaviors, note 60 *infra*, Pennhurst's response has been to restrain persons engaging in maladaptive behaviors. Control of residents is maintained through the use (and abuse) of physical restraints, seclusion and chemical restraints.

Physical restraints include such devices as shackles, straightjackets, chest restraints, security belts, face masks, halters, feet restraints, helmets, mittens, muffs and muff shackles.[61] The use of these devices is common at Pennhurst and it is used in lieu of treatment and for punishment.[62]

One expert described seeing residents' hands tied together, persons tied to a wheelchair by their wrists and persons tied to beds by their wrists and ankles.[63] One resident spent 2,041 hours tied to a bed from August to October of 1976.[64] Another spent 123 hours in hand re-

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60. Tr. 4-123 Lowrie; 1-143 Roos; Nagle Dep. at 56, 73-74. Commonly accepted humane teaching methods are available but not used at Pennhurst. *E.g.*, Tr. 1-123 to 130 Girardeau. This is graphically demonstrated by the experience of one school-aged person at Pennhurst. When at Pennhurst, he was kept in arm restraints which deprived him of the ability to bend his arms at the elbows because he would slap himself. When he was in school, where he had a program, restraints were not used. Nagle Dep. at 64-65, 94.

61. Photos 47-49 at Ex. G-48; Mathews Dep. at 62.

62. Tr. 1-133 Roos; 2-83 Clements; 5-125 to 129 Girardeau; 8-11 Troester; photo 18 at Ex. G-481 Ex. G-39, G-40. Restraints cause injury and death. One eleven year old resident of Pennhurst strangled on the restraints used to tie him to a chair. Ex. P-62. *See* Tr. 2-83 to 84, 87 Clements; 7-130 to 131 Hirst.

63. Tr. 1-134 to 135 Roos.

64. Mathews Dep. at 64-66.

straints during one month and still another spent 690 hours in hand and feet restraints in another month.[65] Not only are restraints dangerous in and of themselves, but their use makes residents more subject to the attacks of others.[66] In addition, participation in programming is physically impossible.[67]

Without notice to or permission from their parents, Pennhurst placed minor plaintiffs in physical restraints.[68] Although she could walk, Linda Taub was tied into a wheelchair so staff would know where she was.[69] Plaintiff Sorotos was restrained:

> He would be tied to the bench. Often he would be walking around the floor, on all fours pulling the bench with him.
> Q. I don't understand.
> A. Well, he would try to get up and he'd fall over. The bench was tied to his back, so he would just drag it around.

Tr. 12-84 Caranfa.

Seclusion, the practice of putting residents alone in a locked room, is also common at Pennhurst.[70] Generally seclusion rooms at Pennhurst are dark, hard surfaced, unpadded, dangerous, and devoid of furniture; these rooms are filthy. Tr. 1-136 Roos (observing feces on the ceiling and old clothes on exposed pipes).[71] Seclusion at

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65. *Id.* at 69, 71.
66. Tr. 2-87 Clements; 5-128 Girardeau.
67. *Id.*
68. Tr. 13-31 Taylor; 2-152 to 153 Taub.
69. *Id.* Taub.
70. Tr. 1-133 Roos.
71. 446 F.Supp. at 1306 n.34; photos 97, 98 at Ex. G-48; Tr. 1-132 to 133, 134 Roos. Pennhurst staff surveyed every seclusion room and, in a written report to the administration, found dangerous conditions including sharp edges, exposed wiring, hot radiators, matches, and smeared feces. Ex. P-56; Tr. 4-179 to 190, 5-4 to 5. As the employee testified, "an animal shouldn't even be placed in a room like that." *Id.* at 4-190 Lowrie.

Pennhurst is used as punishment for such things as rules infractions[72] and setting fires.[73]

Often a seclusion order is written PRN[74] — "an open door putting the individual in the seclusion room anytime they see fit." Tr. 1-134 Roos. One resident of Pennhurst, Joseph O., was kept in seclusion for five years running; his room was hosed down to clean it.[75]

The use of seclusion is unacceptable under professional standards for caring for the retarded because it promotes no positive behavior and, in fact, is regarded by residents as a reward for inappropriate behavior.[76] Use of restraints and seclusion is "totally unacceptable" for habilitation and "essentially condemn[s] the individual to a lifetime of confinement."[77]

The use of drugs to control behavior is by far the most prevalent form of restraint at Pennhurst. Drug practices at Pennhurst fall far short of minimum professional standards and include excessive use of psychotropic drugs, polypharmacy, and the administration of drugs on a PRN basis.[78]

At Pennhurst, psychotropic drugs, *i.e.*, major tranquilizers,[79] are used for behavior control, in contravention of Food and Drug Administration standards on prescription and dosage.[80] About twice as many residents

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72. A former Pennhurst resident testified that a resident could spend five days or two weeks in seclusion for breaking rules. Tr. 8-27 Hill.

73. Ruddick Dep. at 41; in this situation, the use of seclusion was approved by a "business administrative officer." Later, a physician validated the decision without seeing the resident. *Id.* at 44-45.

74. Abbreviation for *pro re nata*, "as is necessary."

75. Tr. 19-75, 124 to 125 Pirmann.

76. Tr. 5-119 to 120 Girardeau; 1-135 to 136 Roos.

77. Tr. 1-135 to 136 Roos.

78. Tr. 3-36 to 38, 42 to 46, 55 Sprague. "Polypharmacy" is the simultaneous use of many drugs. For "PRN," *see* note 74 *supra*.

79. The dangers, nature and effect of these powerful drugs are described at Tr. 3-15 to 22 Sprague.

80. *Id.* at 3-36 to 44.

are receiving psychotropic medication as would normally be expected to require them.[81]

At Pennhurst, medication is used for the convenience of staff and in lieu of habilitation.[82] Often, the use of these drugs prevents residents from benefitting from those few learning experiences available. For example, for many years plaintiff Larry Taylor could not walk and often fell asleep in school as a result of his medication.[83] Pennhurst's polypharmacy policies make it nearly impossible to determine the efficacy of a particular medication.[84] Training of staff in drug use is insufficient and evaluation of practices is improper.[85] Drugs are administered PRN, often by an aide and without a doctor's order.[86] They are also imposed on minor residents without notice to or consent from parents.[87]

Drugs are not a treatment for mental retardation. Pennhurst Acting Medical Director testified, "I don't think that there are any drugs that will change mental retardation." Tr. 19-190 Hedson.

F. Regression

The results of confinement in the institution called Pennhurst are, sadly, predictable. An individual entering

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81. *Id.*; Tr. 2-89 Clements.

82. Tr. 2-88 to 92; 3-53 Sprague.

83. Tr. 13-24, 28, 62 Taylor. Drugs made plaintiff Sorotos "glassy-eyed" and "groggy" at Pennhurst; he was "fine" at home without any drugs. Tr. 12-86 Caranfa. Plaintiff Bowman developed tremors and shakes from drugging at Pennhurst. Tr. 13-86, 87 to 90 Bowman. *See* 446 F.Supp. at 1308, 1310; 32a-33a, 38a, 39a.

84. Tr. 2-90 to 92 Clements; 3-26, 32, 34, 37, 41, 45, 51 Sprague; Hedson Dep. at 59-61.

85. Ex. G-33; Tr. 3-34, 42-46 Sprague. A testifying expert observed and had photographed a resident being forcibly and dangerously drugged on the floor at Pennhurst. Photo 38 at Ex. G-48; 2-136 to 137 Clements.

86. Boyle Dep. at 38; Tr. 16-79 Boyle; 18-71 Pool.

87. *E.g.*, Tr. 13-24 Taylor; 13-72 Bowman.

Pennhurst can only become more handicapped. The conditions at Pennhurst "are likely to foster regression, maladaptive behavior, and curtailment of mental, personal, social and physical development. Among these conditions I would emphasize enforced idleness, mass living and regimentation, an environment which deviates markedly from the normative." Tr. 1-177 Roos.

As the District Court concluded, "the environment at Pennhurst is not only not conducive to learning new skills, but it is so poor that it contributes to losing skills already learned." 446 F.Supp. at 1308; 34a (citations to record and note omitted). *Accord*, Tr. 1-151 to 152 Roos; 58-59 Clements; 4-73 Lancaster-Gaye; 4-34 to 35 Flueck (study of random sample of records); 7-116 to 118 Hirst; 7-65 to 67 Dybwad.

Plaintiff Terri Lee Halderman was known to be "apt to regress."[88] Yet, from the time she entered Pennhurst, Ms. Halderman received no programs to prevent regression.[89] Residents of Pennhurst who, like Ms. Halderman, enter the institution able to speak, cease to do so because the noise level on the wards is so high that individual conversation is impossible.[90] Not only are residents deprived of the ability to learn new skills in the institution, the conditions therein make inevitable the loss of other acquired skills.[91]

The intellectual and behavioral deterioration inflicted by Pennhurst is a common denominator affecting all residents. Those who, in addition to mental retardation, also suffer physical handicaps, are doubly injured by life at Pennhurst.[92] Those residents fortunate enough to have wheelchairs often do not have chairs which are

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88. Ex. P-66 (Halderman records); Tr. 8-75, 128 to 129 Hirst.

89. *Id.* at 8-80.

90. Tr. 9-88 Halderman, 9-40 Hunsicker; 2-59 Clements; 7-126 Hirst. *See* Tr. 2-170 Taub (plaintiff's functioning "went down.")

91. 446 F.Supp. at 1308; 34a; Tr. 1-96, 100, 151 Roos.

92. 446 F.Supp. at 1305; 26a n.28.

appropriately designed for them.[93] Those who do not have wheelchairs are transported in makeshift wheeled tables known as "cripple carts." And those who lack "cripple carts" are confined to their beds, often on "crib wards." With the absence of physical therapy and the lack of needed equipment, physically handicapped residents develop contractures, the freezing and atrophy of unused muscles, which, in some cases, can only be remedied (if at all) by radical surgery.[94]

G. Potential for Improvement of the Institution

The most telling commentary on the facts of life at Pennhurst is that provided by three retardation experts who, the defendants' counsel told the court, were "clearly retained by us to help us in the defense of this litigation." Tr. 13-148 (Deputy Attorney General Watkins). After a vigorous struggle over the admissibility of their testimony, Tr. 12-3 to 15, the experts summarized their three-month study, embodied in a 350 page report, with a 1,000 page appendix, and a separate paragraph-by-paragraph analysis of the complaint.[95]

The defense team attempted to answer four questions:

> First, what is the role of an institution in the service delivery system. Number 2, is an institution an appropriate educational treatment facility; 3 is Pennhurst an adequate setting; and 4 if not, can Pennhurst be made an adequate facility?

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93. 446 F.Supp. at 1304-1305; 25a-26a; Tr. 20-99 to 101 Fekula.

94. Photo 12 at Ex. G-48; Tr. 2-50 to 51, 55-57 Clements; 4-74, 75 Lancaster-Gaye.

95. Tr. 13-125 to 126 Hersh. The $12,000 contract for the "comprehensive, objective evalaution of Pennhurst," *id.* at 13-117, is PARC Ex. 71. The District Court declined to require the defendants to produce the written report.

Tr. 13-119 Hersh.[96] In response to the first question, they concluded that

> the institution has pretty much lost its role, that it is essentially an obsolete way of treating people. It is based on a series of assumptions which are dated. * * * So that the conclusion we came to is that there is no role for an institutional service delivery system in Pennsylvania.

Id. at 13-128 to 129. An institution was found to be an inappropriate educational treatment facility. Tr. 13-129.

On the third question, Pennhurst was found inadequate:

> We found in many ways that the staff of Pennhurst were really fine people, they were hard-working people, they were doing their best. However, we came to the conclusion that because of the essential obsolescence of the total system and because of the complexity of the interpenetration of the various systems — Southeastern Pennsylvania, child-welfare system, mental retardation system, et cetera, et cetera, that having evaluated all the factors that we could put our hands on we came to the conclusion that Pennhurst is not an adequate facility.

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96. For brevity, the testimony of only one witness, Dr. Alexander Hersh, is presented here. One of the others, Dr. Valaida Walker, former Pennsylvania Department of Public Welfare Regional Mental Retardation Commissioner, cited the team's recommendation that, once its residents were provided individualized services elsewhere, "the name of Pennhurst be abolished completely and never be attached to any part of the facility whatsoever for obvious reasons." Tr. 14-7 to 8. The other team member is expert Dr. Kenneth Thurman.

Tr. 13-130. And it cannot be sufficiently improved:

> We came to the conclusion that it could not, that there is no way that Pennhurst could be made into an adequate facility. It is simply too far beyond repair and there are just literally hundreds of reasons why this is the case, not the least of which is the fact that Pennhurst as the whole structure, the whole way of operating out there is simply too far gone.

Tr. 13-131. The views of defendants' experts were shared by every expert for plaintiffs.

The defendants — state and counties alike — have been unable, despite more than fifteen years of planning and effort, and despite the availability of $21,000,000 earmarked for Pennhurst dispersal, to alter the life imposed on plaintiffs.[97]

H. Community Services

There is a world for the retarded outside Pennhurst. The institution's staff, from social worker to superintendent, agree that all its residents can be better served in small facilities in the community, and the Department of Public Welfare agrees;[98] the state, in fact, had slated Pennhurst to be emptied under a five-year plan.[99]

All persons living at Pennhurst, including the most severely mentally and physically disabled, should receive services and habilitation in the community; people

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97. *See* facts at notes 194-196 *infra*; Tr. 14-10 to 24 (former state retardation Commissioner Walker); 6-165 to 166 Settle. After years of effort, the Willowbrook institution remains unfit for human habitation. Tr. 2-108 Clements.

98. Tr. 8-166 to 167 Hindman; 1-185 Roos; 2-111 Clements; 22-171 to 172 Youngberg; 22-77 Foster; 26-22 Rice; Youngberg Dep. at 102; Foster Dep. at 63.

99. Tr. 28-46, 48 Rice; facts at note 195 *infra*; 446 F.Supp. at 1313; 47a-48a.

with identical disabilities — Pennhurst residents' "twins" — in Pennsylvania are receiving such habilitation *now*.[100]

The graphic contrast between life at Pennhurst and life in the community with needed services was best related at trial by individuals who left the institution.

After spending ten years at Pennhurst, Robert Troester now lives in a Doylestown, Pennsylvania, group home with seven other men. He now has his own room, does his own cooking and helps with the shopping. Each day he takes public transportation to his sheltered workshop, where he is employed as a collator. He enjoys going to movies and restaurants in the Doylestown area. Tr. 8-13 to 19 Troester.

After years at Pennhurst, Robert Hill lives in the community, and works in a delicatessen, "five days, except holidays and Saturday and Sunday." Tr. 8-29 Hill. In his leisure time, Mr. Hill enjoys television, walking or fishing, and mystery novels. *Id.* at 8-27 to 31.

Robert Vaughn spent thirteen years at Pennhurst. He now lives in a group home and is employed as a dishwasher in a local department store. To get to his job he must take three different buses. He is an usher in his church. Tr. 8-39 to 42 Vaughn.

These examples are not aberrations, but rather are typical experiences of Pennhurst residents who return to the community.[101] They also are not attributable to a lack of disability or a lack of behavior problems. Grace Auerbach, the mother of Sidney Auerbach, age 51, who was severely retarded and a resident of Pennhurst for 38 years, described the difference in her son. At Pennhurst,

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100. 446 F.Supp., at 1311; 42a-43a; Tr. 1-183, 185, 190 Roos; 2-84, 111, 125 Clements; 5-161 Girardeau; G-25 to 26, 29 to 31, 35 Glenn; 7-68 to 71 Dybwad; 14-21 Walker; 19-69 to 70 Pirmann; 27-101 Rice.

101. *E.g.*, 10-74, 75, 87 Wood; 10-110 Brown; 10-166 to 167 Bolin; 11-72 to 73, 80 to 81 Kulp.

Mr. Auerbach never spoke. Now, his mother testified, he speaks continuously. He now cooks for himself, holds a job, and keeps his own bank account. Tr. 8-44 to 8-62 Auerbach; 446 F.Supp. at 1311 n. 47; 42a. Residents who engaged in assaultive behavior, temper tantrums and soiling themselves, after six months in a community placement, no longer displayed such activity. Tr. 10-166 to 174 Bolin.

Community living embraces the use of a large spectrum of services, some of which are used as a matter of course by non-retarded persons. A "house-type" residential setting is only "one of many different possibilities" for community care; "We know, of course that there are many other models, including foster placement, family placement, and apartment living, independent living." Tr. 1-207 Roos. In some cases, "a small community-based institution" may be necessary to meet the needs of an individual. *Id.* at 1-208. Other existing residential possibilities include subsidized relatives' homes and supervised apartment clusters.[102] The type of arrangement depends on the needs and abilities of the prospective resident.

In addition to, and reducing the need for, residential placement outside the family home, there exists a continum of services designed to serve the retarded person in the community. These services include early intervention and infant stimulation programs, nursery and pre-school programs, public school programs, pre-vocational and vocational training, and independent employment.[103]

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102. *See, e.g.*, note 4 *supra*; Tr. 2-96 to 97 Clements; 6-18 to 20 Glenn; 5-141 to 161 Girardeau; photos 89, 90, 91, 94, 95 at Ex. G-48.

103. *E.g.*, Photos 57, 58, 89, 93 at Ex. G-48; 5-141, 142, 159, 161 Girardeau; 6-6 to 8, 14 Glenn; 6-95 to 98, 172 to 174 Settle; 10-11 to 32, 45, 60, 65; 11-31 Miller.

With 85% of the retarded capable of gainful employment, Tr. 6-95 Settle, and with vocational services operating in the area surrounding Pennhurst, it is no surprise that the typical response of former residents to the provision of vocational services is tremendous progress, including participation in competitive employment.[104]

It is "considerably less costly to provide for mentally retarded persons in the community than in institutions." Tr. 12-20 Conley (expert retardation economist; based on Pennsylvania costs). In 1977, per-resident annual average cost was $20,000 at Pennhurst and $14,000 in the community. *Id* at 12-22, 23, 35; 446 F.Supp. at 1312; 44a (per diem costs: $64 v. $28). For example, for Montgomery County residents in Pennhurst at a $3.3 million annual cost, it would require $1.9 million to provide habilitation outside that facility. Tr. 12-15. State Commissioner Rice acknowledged at trial that the cost of Pennhurst would more than cover the community care cost for all its residents. Tr. 27-39 to 40.

Existing community services for the retarded in Pennsylvania, including those for former Pennhurst residents, are "excellent," "highly developed," "very good."[105] Funds are available for further development of such services. 446 F.Supp at 1312; 43a-44a; notes 194, 195 and 196 *infra*. Both the state and the county defendants are responsible for the monumental and needless incarceration of human beings under Pennhurst's regime.[106]

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104. Photos 57, 58, 93 at Ex. G-48; 8-16 Troester; 8-29 Hill; 8-40 Vaughn; 10-74 to 75 Wood; 10-106, 110 Brown; 10-166 to 167 Bolin; 11-40 to 43 Miller; 11-72 to 73, 80 to 81 Kulp.

105. Tr. 12-26 Conley; 6-50 Glenn; 5-141 to 161 Girardeau. Other states have community services of considerable quality for severely and profoundly retarded persons. Tr. 28-45 Rice; 1-198 to 199 Ross.

106. On direct county involvement, *see* 446 F.Supp. at 1212-1213; 45a-46a; 612 F.2d at 103; 129a-130a.

The crisis that is Pennhurst and its resolution were correctly characterized by its Superintendent, Dr. C. Duane Youngberg:

> As I said a number of times, it is not mental retardation *per se* that requires the institution. It is just the lack of alternative resources . . . I often say that it is not a matter of our people getting ready to return. It is a matter of the community getting ready to take their people back.

Youngberg Dep. at 102.

Supreme Court, U. S.
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Nos. 79-1404, 79-1408, 79-1414, 79-1415, 79-1489

IN THE

Supreme Court of the United States

October Term, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,
Petitioners,

v.

TERRI LEE HALDERMAN, et al.,
UNITED STATES OF AMERICA, and
PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, et al.,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Third Circuit.

BRIEF OF RESPONDENTS AND CROSS-PETITIONERS PARC, et al.

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QUESTIONS PRESENTED

1. Does Section 111 of the Developmentally Disabled Assistance and Bill of Rights Act prohibit Pennsylvania from subjecting retarded persons to the regression, isolation and custodial conditions found by the trial court to exist at Pennhurst?

2. Does 42 U. S. C. § 1983 provide a remedy to enforce Section 111 of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U. S. C. § 6010 ("Section 6010")?

3. Does Pennsylvania law support the judgments of the courts below?

4. Did the trial court abuse its discretion in granting relief which would prohibit the use of Pennhurst as a residence for retarded people and require provision of treatment, services and habilitation in the community?

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New York State Association for Retarded Children v. Carey, 393 F. Supp. 715 (E. D. N. Y. 1975) 18

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Other Authorities: Page

E. Butterfield, "Some Basic Changes in Residential Facilities" in President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded 15 (2d ed. 1976) 47
E. Goffman, Asylums (1962) 14
The Menace of the Feebleminded in Pennsylvania (C. H. Frazier, Chrmn, Public Charities Assn. of Pa., 1913) (pamph. col., Hist. Soc. of Pa.) 14
Note, "Implementing Institutional Reforms," 91 Harv. L. Rev. 428 (1977) 48
R. C. Scheerenberger, Public Residential Services for the Mentally Retarded (1976) 3, 47
P. Tyor, Segregation or Surgery: The Mentally Retarded in America (Northwestern University Ph.D. diss. 1972) ... 14
Secretary's Committee on Mental Retardation, Mental Retardation Construction Program (March 1969) 16
President's Committee on Mental Retardation, MR 68: The Edge of Change 17
President's Committee on Mental Retardation, MR 69: Toward Progress—The Story of a Decade 17
President's Panel on Mental Retardation, A Proposed Program for National Action to Combat Mental Retardation 14 (1962) 15
W. Wolfensberger, "The Origin and Nature of Our Institutional Models" in President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded (1st ed. 1969) 14
C. Vann Woodward, The Strange Career of Jim Crow (Oxford Rev. Ed. 1957) 14
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Nos. 79-1404, 79-1408, 79-1414, 79-1415, 79-1489

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Respondents

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF OF RESPONDENTS AND CROSS-PETITIONERS PARC, et al.

STATEMENT OF THE CASE

Pennhurst opened in 1908. Its founding, "on such scale as will create an institution to accommodate not less than five hundred inmates or patients, planned and located for easy and natural additions, as population demands," was commissioned by Act of May 15, 1903, 29 *Laws of Pennsylvania* 446, and its legislative charge, "to be devoted to the segregation . . . of epileptic, idiotic, imbecile, or feeble-minded persons" was set by Act of June 12, 1913, 32 *Laws of Pennsylvania* 494.

Pennhurst is located approximately thirty miles outside of Philadelphia, its large buildings set together in the middle of six hundred acres. At the time of trial Pennhurst housed 1,230 retarded people. (104a). The conditions to which the Pennhurst institution has subjected retarded people comprise the subject matter of this case.

The factual findings establish that the "abominable conditions" at Pennhurst (103a, 162a) chronically impose regression, abuse and injury upon its retarded residents, destroying skills they had previously learned and possessed at the time of their admission.[1] (20a, 58a; 105a-106a, 162a).[2]

The findings establish that these conditions of routinized, massed and impersonal treatment of retarded people existed at Pennhurst throughout its seventy years. (19a, 58a). They establish how and why Pennhurst is "one of the worst institutions of its kind in the world." (162a).

At trial and at the further hearings on remedy, state and county defendants themselves asserted, as they had for the preceding decade, that (1) Pennhurst is an impos-

1. The findings made by the district court Judge Raymond J. Broderick were upheld unanimously by the Court of Appeals *en banc*. Petitioners contest none of the findings in this Court.

2. Appendix references are to state and county petitioners Joint Appendix to the Petitions for Writ of Certiorari filed in Nos. 79-1404, 79-1408, 79-1415, paged 1a-240a, and to the Joint Appendix of all parties, to have been filed October 20, 1980, paged 241a-1166a.

sible and defeating environment for providing habilitation services to severely retarded people; (2) that real and extensive efforts to improve Pennhurst had failed to alter the conditions to which Pennhurst subjects its residents; (3) that no one at Pennhurst needs an isolated or large institution for their habilitating treatment; everyone there can be better served in family-scale residences in the general community; and (4) that their own choice of remedy for the conditions at Pennhurst and to secure habilitation for its residents was to replace the institution with proper community-based residential settings and other community services. (42a-43a, 47a-48a, 78a, 105a). Defendants had so admitted for the decade previous to trial, they had only failed to act on this admission. (46a, 78a).

This action began on May 30, 1974. Eight retarded people, residents of Pennhurst, and the Parents and Family Association of Pennhurst, an organization of 200 parents of Pennhurst residents, were the original plaintiffs, seeking injunctive relief and damages. (15a-16a). The United States, asserting its interests under four federal statutes and seeking injunctive relief, was granted leave to intervene as a party plaintiff on January 17, 1975. (16a). Four additional retarded people, residents of Pennhurst, and the Pennsylvania Association for Retarded Citizens intervened as plaintiffs on November 12, 1975, seeking only injunctive relief.[3] (16a).

By amended complaint, filed January 8, 1976, claims under the newly enacted Bill of Rights provision of the Developmentally Disabled Assistance and Bill of Rights Act of 1975, under Section 504 of the Rehabilitation Act of 1973, 29 U. S. C. § 794 and under state statute were

3. The Pennsylvania Association for Retarded Citizens was founded in 1950 and at the time of trial had "chapters in fifty-seven of Pennsylvania's sixty-seven counties, its purpose being to advance the interest of retarded persons in Pennsylvania. [Its] members include parents, other relatives, guardians and next friends of persons residing at Pennhurst and those in jeopardy of residing there." (18a).

added to the original constitutional claims under the Due Process Clause, the Equal Protection Clause and the First, Eighth and Ninth Amendments. (96a). On November 26, 1976, the plaintiff class was certified.[4]

Jurisdiction arose in the district court under 28 U. S. C. § 1331 and § 1343, the action being one to redress the deprivation by state and county officials of rights secured by, inter alia, 42 U. S. C. § 1983 and § 6010 (9a, n. 2) and by the Constitution. Jurisdiction of the state law ground arose by virtue of pendent jurisdiction.

The action was heard by Judge Raymond J. Broderick during 32 trial days, from April 18, 1977 until June 13, 1977. Judge Broderick heard the testimony of eighty witnesses, half offered by plaintiffs and half by defendants,[5] and received into evidence 27 depositions of defendants and their managing agents, 108 photographs, a three-hour videotape presented by defendants, and 288 documentary exhibits.[6] On December 23, 1977, the district court denied

4. The district court's class determination was upheld unanimously by the Court of Appeals (144a), and as to it, certiorari was denied by this Court. 100 S. Ct. 2984 (1980).

5. Plaintiffs' witnesses included fourteen expert and twenty-six fact witnesses, including eleven parents of Pennhurst residents (e.g., 611a, 695a, 362a, 733a) and three retarded people, two severely retarded, who had formerly resided at Pennhurst (588a, 595a, 603a) and three experts (testifying under authority of *Nevels v. Ford Motor Co.*, 439 F. 2d 251 (5th Cir. 1971)), who had been retained by defendants to conduct a three month study of Pennhurst. (574a, 779a, 793a).

6. The courts below found that 74% of the people at Pennhurst were severely or profoundly retarded (20a, 104a), which is exactly the proportion that obtains on the average in the other public retardation institutions, Scheerenberger, *Public Residential Services for the Mentally Retarded 1976*, 12. Some Pennhurst residents also have the physical disabilities which often accompany severe retardation, namely, cerebral palsy (21.2% at Pennhurst; 19.9% nationally) and epilepsy (27.3% at Pennhurst, 29.7% nationally).

original plaintiffs' money damage claims, but otherwise entered judgment for plaintiffs.

Judge Broderick held that the conditions of Pennhurst violate the rights of retarded people under the Due Process Clause and Equal Protection Clause of the Fourteenth Amendment, the Eighth Amendment proscription of Cruel and Unusual Punishment, Section 504 of the Rehabilitation Act of 1973 and under state statute. The district court made dual findings, both that no individual at Pennhurst needed to be there, each could benefit from the proper community services, and that Pennhurst itself was a pun-

6. (Cont'd)

From the beginning plaintiffs specifically focused on severely retarded people to demonstrate (1) that severely retarded people especially require structured, individual address to learn, maintain and exercise life-skills; (2) that individually structured attention is not now and never has been available or possible at Pennhurst; and, (3) that such individually structured attention is possible, likely, and in fact present in family-scale community living arrangements provided by defendants in Pennsylvania. Plaintiff PARC's Ex. 48, 1003a, presented the disability facts concerning Pennhurst residents and every witness testified in terms of the severely retarded, *e.g.*, Roos, 260a and Clements, 310a (the developmental approach); Dybwad, 545a, Girardeau, 449a (the conditions of learning); Girardeau, 455a, Glenn, 481a, Bolin, 684a (community living arrangements); Glenn, 488a, Roos, 273a (speech and communication); Clements, 329a, Lancaster-Gaye, 417a (individually adapted wheelchairs for people with severe cerebral palsy); Settle, 517a (vocational services); Hersh, 772a (effective seizure control for people with epilepsy).

The suggestion by Amici Congress of Advocates, et al. that specific problems of severely retarded people were not addressed in the trial court betrays a failure even to glance at the record of this case, let alone to read it.

Throughout this Brief, severely or profoundly retarded people including those with additional physical disabilities are referred to as "severely retarded people," for the record shows the conditions of learning are similar across this range of disability and "require similar treatment and services." See 42 U. S. C. § 6001(7) (1976).

ishing institution which could not practically be rehabilitated. In summary of its findings, the court wrote:

> On the basis of the evidence presented in these proceedings, we find that the retarded residents of Pennhurst have not received, and are not receiving, minimally adequate habilitation. Furthermore, on the basis of this record we find that minimally adequate habilitation cannot be provided in an institution such as Pennhurst. As the Court has heretofore found, Pennhurst does not provide an atmosphere conducive to normalization which is so vital to the retarded if they are to be given the opportunity to acquire, maintain and improve their life skills. Pennhurst provides confinement and isolation, the antithesis of habilitation. We found that Pennhurst has produced regression and in many instances has destroyed life skills possessed by its retarded residents at the time of their admission. (58a).

At two further hearings on remedy, state and county defendants reaffirmed their express policy that all retarded people should be removed from Pennhurst and the institution should be closed, but refused to offer to the court any remedial plan except the one offered at trial which the court found to be "vague and indefinite." (77a-78a).

Thus to remedy the harm imposed by unlawful conditions at Pennhurst, Judge Broderick concluded that "our Order must provide that immediate steps be taken to remove the retarded residents from Pennhurst." (77a). Mindful that "[g]reat caution and care must be taken to make certain that each and every retarded resident who is moved from Pennhurst can be accommodated in a community facility which will provide minimally adequate habilitation," Judge Broderick ordered state and county defendants to provide suitable community living arrangements and other community services to plaintiffs and to establish monitoring mechanisms, including individualized program plans, which would assure their quantity and

quality, and to take certain measures to minimize harm to residents during the interim operation of Pennhurst. (79a-88a). The court appointed a Master to oversee the transfer of residents and to assure the presence of safeguards in the community and in Pennhurst's interim operation. (80a-81a).

After argument and reargument *en banc* on its own motion, the Court of Appeals *en banc* unanimously concurred in the trial court's findings of fact (103a-108a, 155a-56a, 162a, 163a) and, dividing 6-3,[7] affirmed the judgment and orders of the district court in all respects but three.[8] (161a). Even the three judges in dissent would have held that "the conditions at Pennhurst revealed in this record fall below a statutory or constitutional threshold of decency so as to merit judicial intervention." (162a).

Contrasting starkly with "the abominable conditions to which Pennhurst residents have been subjected" (103a), the Court of Appeals found:

> ". . . Pennsylvania operates small and less isolated programs referred to as Community Living Arrangments (CLAs). The latter programs reflect a recognition of the principles of normalization for the habilitation of the retarded. Under normalization principles, retarded persons are treated as much as possible like nonretarded persons. The purpose of such treatment is remediation of the delayed learning process so as to develop maximum potential in self-help, language, personal, social, educational, voca-

7. Circuit Judges Gibbons, Rosenn, Weis, Garth, Higginbotham and Sloviter joined in the Court's judgment and opinion. Chief Judge Seitz, Judges Aldisert and Hunter dissented. Judge Adams did not participate.

8. One of these, an order to provide alternative employment for Pennhurst employees, was not the subject of conditional cross-petition here. The other two, an order providing for the eventual closing of Pennhurst and another prohibiting admissions to Pennhurst, were, and certiorari was granted at No. 79-1414.

tional and recreational skills. These remediation efforts, the trial court found, are, in general, much more likely to succeed in small living units which are closer to and more reflective of the normal society." (105a).

The Court *en banc* did not reach the constitutional grounds (108a, 131a) or Section 504 (141a), but rested its judgment upon Section 6010, the Bill of Rights provision of the Developmentally Disabled Assistance and Bill of Rights Act of 1975 and upon the Pennsylvania statute.[9] The Court *en banc* held that § 6010 provides retarded people a statutory right to habilitation (109a) and, finding that "the clear preference of the Act is deinstitutionalization" (140a), "institutionalization [being] strongly disfavored" (159a), the Court held that § 6010(1), (2), and (3)(A), as well as the state statute (151a), states "a presumption in favor of placing individuals in C[ommunity] L[iving] A[rrangement]s." (159a).[10]

9. Section 6010, contrary to Petitioners' assertion (Br. 6, n. 12), was pleaded by all plaintiffs, the U. S. complaint invoking its predecessor Act, briefed in the district court on preliminary injunction, specified as at issue in the pretrial order, and, with other contemporaneous related enactments of the Congress, was briefed in opening briefs in the Court of Appeals. (9a, n. 2). As of the date of the district court opinion, this Act had been mentioned in dicta in one case, but no case resting upon the Act had been decided. Chief Judge Pettine's decision in *Naughton v. Bevilacqua*, 458 F. Supp. 610 (D. R. I. 1978), *aff'd. in part* 605 F. 2d 586 (1st Cir. 1979), was the first holding invoking § 6010.

10. Contrary to Petitioners' assertion (Br. 38, n. 59), community living arrangements were not undefined in the court record. Defendants' documents defining Pennsylvania's eight types of community living arrangements are in the record as PARC Exhibits 63 (1029a), 64 (1032a), 33 (986a). At the time of trial, 3,437 retarded Pennsylvanians, including severely retarded people, had resided in community living arrangements. PARC Ex. 64, 1032a. See testimony of state officials at 928a, 941a, 863a-864a.

The Court *en banc* held that "institutionalization . . . is not foreclosed completely by the governing federal and state statutes" (159a) and, on that ground, vacated the district court orders providing for "the eventual closing of Pennhurst" and prohibiting admissions to Pennhurst (161a). The Court "remanded for individual determinations by the court or the Special Master as to the appropriateness of an improved Pennhurst for each such person." (156a). Under both statutes, the Court held, the standard on remand is:

> "Only where . . . an improved Pennhurst is the only appropriate place for [habilitating] individual[s] should it be used. For all other[s] CLAs must be provided." (160a).[11]

The dissent "agree[d] with the majority that the legislative history indicates a preference for least restrictive treatment" (165a) and with the district court that "given proper facilities, all of these persons [the Pennhurst residents] could be served 'in the community'" (173a), but the dissent could not find in the language of § 6010 "a general right to individualized treatment in the least restrictive environment." (164a). The dissent "assum[ed]" although it did not find, that there could be "a Pennhurst without the deplorable living conditions here" (163a). The dissent conceded, "I do not know what a properly run Pennhurst would be like" (192a), but nonetheless would have ordered "improvement of Pennhurst" and "require[d] the state to eliminate the deplorable conditions at Pennhurst" (163a), apparently on the basis of a constitutional right under the Due Process Clause (191a-193a), "apply[ing] to every individual, whether inside or outside an institution" (192a)—a right to "adequate living conditions" (162a), or to "minimally adequate

11. The Court of Appeals did not direct the district court to order "improvements" beyond those the court had originally entered for the interim operation of Pennhurst. (160a).

supervision and care" (192a), or to "adequate food, shelter, medical care and other necessities" (193a).[12]

On June 9, 1980, the Court granted certiorari on petitions of state, suburban county, and Philadelphia defendants and a post-judgment intervenor and granted the conditional cross-petition of respondents PARC, et al. The Court specified an additional question: "Does 42 U. S. C. § 1983 provide a remedy to enforce the provisions of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U. S. C. § 6000 et seq.?" 100 S. Ct. 2984 (1980).

On June 30, 1980, the Court granted a partial stay of the judgment and orders below; four Justices would have denied a stay entirely.

SUMMARY OF ARGUMENT

I. In Section 6010 Congress acted to end warehousing of severely retarded people in custodial institutions and to require developmental services. For decades public retardation institutions unsuitable for treatment, education and habilitation programs had offered only regression and abuse to severely retarded people. By Section 6010 Congress unequivocally established their "right to appropriate treatment, services, and habilitation," requiring services "designed to maximize their developmental potential" in "the setting least restrictive of . . . personal liberty." The statute bans custodial institutions; it does not categorically prohibit all large, isolated institutions, but establishes a strong presumption against them and in favor of family-scale, community-based facilities.

Section 6010 expresses the Congress' long-standing concern to ensure equal citizenship for severely disabled people and its recognition that Congressional efforts since

12. The dissent assumed (164a), but did not indicate whether it would decide, that § 6010 provides "a right to treatment" (164a) and that the state statute provides "a statutory right to some kind of treatment." (175a).

1963 to encourage the states to abandon their injurious institutions and instead develop community-based services had yielded disappointing and meager results. Congress' resolve was informed by the experience of the federal courts which, absent Congressional direction, had responded under the Constitution to halt the continuing detriment imposed by custodial institutions, by opening public education to severely retarded people and by seeking, first and unsuccessfully, to reform the character of custodial institutions like Willowbrook and then turning instead to small, community facilities.

During four legislative years, 1972-1975, Congress intensively examined the situation of severely retarded people. In a series of related enactments, Congress required the states to include severely retarded people in service programs and to act to maximize their developmental potential. In 1975 by Section 6010 Congress imposed a paramount framework upon "the Federal Government and the States both" to direct the expenditure of some $3,168 billion annually in federal contributions to retardation services.

Section 6010 embodies Congress' judgment that most large, isolated institutions are irretrievably custodial, and would have to be phased out and replaced by community services. Eschewing extensive, detailed standards, Congress declared the rights essential to effectuating its judgment and directed that "public funds" not be spent upon any custodial "institutional or residential program." Congress thus directed courts to scrutinize the institutional or residential program. The trial court was faithful to this direction and the Congressional intent, which obviates unnecessary judicial interventions into professional judgments concerning individual needs.

II. Neither the language of Section 6010 nor its extensive legislative history gives any indication that Congress intended to rely exclusively upon administrative enforcement to ensure disabled people their rights, or to

displace judicial enforcement; to the contrary. *Maine v. Thiboutot,* 100 S. Ct. 2502 (1980), settles the question whether 42 U. S. C. § 1983 provides a judicial remedy to enforce Section 6010. The personal rights and entitlements established by Section 6010 are grounded in Congress' plenary powers under the Fourteenth Amendment and the Spending Clause and their deprivation may be directly enjoined by a court of equity. Decisions of this court have not limited relief to cutting off federal funds.

III. In the first legislative response by any state to the 1963 Presidential and Congressional initiatives, Pennsylvania's 1966 Act required the state and counties to provide adequate retardation services "to every citizen in every community which are available now only to a lucky few, in the more progressive communities" (A-2), as both courts below held. As they found, there is no issue here whether respondents' rights under state law are conditioned on the availability of funds; the cost of community living arrangements and services for all Pennhurst's residents is less than the cost of Pennhurst's maintenance; $18 million in capital funds authorized by the Legislature in 1970 specifically to provide community facilities for Pennhurst residents was available but unspent; during four years before trial the four counties returned to the state, unspent, $7 million for community services.

IV. The detailed record of regression and abuse of severely retarded people in Pennhurst, of the failure of recurrent attempts to improve Pennhurst, the acknowledgement by defendants that in their judgment Pennhurst can not be fixed up and that throughout the decade before trial state policy had been to replace Pennhurst entirely with community-based facilities and services, warrant the orders of the district court entered in this case. The district court's orders carry out the Congressional mandate to phase out custodial institutions and to develop alternative community-based services.

ARGUMENT

I. Congress in Section 6010 Prohibited Custodial Institutions; the Presumption Thus Created Against Large Isolated Institutions Was Properly Applied to Require That Pennhurst Be Phased Out and Alternative Community-Based Services Be Provided.

Congress has made the dispositive decision regarding the question in this case—the propriety of custodial institutions for severely retarded people. In Section 6010, the Congress established the personal rights of severely retarded people and their entitlement to treatment, services and habilitation; by its terms, Congress acted "to change the tragic warehousing of human beings that has been the product of insensitive Federal support of facilities providing inhumane care and treatment of the mentally retarded." 121 *Cong. Rec.* 16519 (1975). Several federal statutes currently provide more than $3.168 billion annually to the states for retardation services.[13] Acting under its power to direct this spending and its power to enforce the Fourteenth Amendment, the Congress undertook to end custodial warehousing and to guarantee severely retarded people the treatment, services and habilitation which can free their very considerable capabilities for citizenship.

South Carolina v. Katzenbach, 383 U. S. 301 (1966) (the Voting Rights Act of 1965 Case), respondents submit, is the model for analysis of Section 6010. In both instances, the problem was an historic and deeply intractable one. As to both problems, Congressional enactments several times over more than a decade had yielded dis-

13. *E.g.*, the Rehabilitation Act of 1973, 29 U. S. C. § 701 *et seq.*; the Education for All Handicapped Children Act of 1975, 20 U. S. C. § 1401 *et seq.*; the Social Security Act, titles XIX and XX, 42 U. S. C. §§ 1396d(d) and 1397, as well as the program assistance provisions of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U. S. C. §§ 6000-6009, 6013, *et seq.*

appointing results. In formulating the statutory course it ultimately took, the Congress in both instances drew upon the experience of the lower courts acting under the the Constitution without benefit of any Congressional standard, adopting some of the remedial directions those courts had taken, discarding others.

In enacting the Voting Rights Act of 1965, Congress did not conclusively ban literacy tests; instead it erected a strong statutory presumption against them and required states to overcome a considerable burden of proof to sustain tests which common and persistent experience showed had been applied abusively. The Bill of Rights Act, at issue in this case, expresses the same Congressional judgment. After twelve years of effort by Congress and courts to improve shockingly abusive conditions in state institutions for mentally retarded persons, the Congress concluded that "the unsuccessful remedies . . . prescribed in the past would have to be replaced by sterner and more elaborate measures." *South Carolina v. Katzenbach, supra,* 383 U. S. at 309. Accordingly, in Section 6010 Congress mandated the end of custodial care by requiring developmental services. As with literacy tests in the Voting Rights Act, Congress did not foreclose the possibility of any institutional programs but rather required states to discharge an evidentiary burden by demonstrating in judicial proceedings that large, isolated institutions would not violate the "right of [severely retarded] persons to . . . treatment, services, and habilitation . . . designed to maximize [their] development potential . . . and provided in the setting that is least restrictive of . . . personal liberty." This judicial role is well within the competence and traditional functions of courts in applying Congressionally enacted standards, guided by expert testimony in adversary proceedings, to ensure that state agencies respect the rights of citizens.

Congress, addressing the legacy of large isolated institutions created by states in the early 20th century to segregate "epileptic, idiotic, imbecile or feeble-minded

persons,"[14] had sought in a series of enactments beginning in 1963 to encourage the displacement of such institutions by funding the development of community alternatives for severely retarded people. But incentives failed. In 1975 the Congress, therefore, required state and federal governments to fund only institutions or residential programs which are designed to maximize their potential and least restrictive of their personal liberties. In so doing—as both the majority and the dissent in the Third Circuit recognized (140a, 159a, 165a)—the Congress expressed its clear preference for community facilities, and established a strong presumption against institutions which are larger than family-scale and isolated.[15] This presumption must guide the courts and govern the actions of "the Federal Government and the States both". In applying this presumption which concerns programs, courts will not face the problems presented by the Third Circuit's individual

14. The origins of these institutions is told in P. Tyor, *Segregation or Surgery: The Mentally Retarded in America* (Northwestern University Ph.D. diss. 1972); W. Wolfensberger, "The Origin and Nature of Our Institutional Models" in *President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded* (1st ed. 1969). Compare C. Vann Woodward, *The Strange Career of Jim Crow* (Oxford Rev. Ed. 1957). See also *The Menace of the Feebleminded in Pennsylvania* (C. H. Frazier, Chrmn, Public Charities Assn. of Pa., 1913) (pamph. col., Hist. Soc. of Pa.).

15. Social Security Act, Title XIX regulations reflect the common distinction between small family-scale institutions of 4 to 16 and large institutions of 17 or more where retarded persons are provided services in addition to room and board. 42 C. F. R. § 435.1009 (1979). Often on the record of this case and in Congressional discussion itself the word "institution" is used as E. Goffman, *Asylums* xiii (1962) defined it ("a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life") and hence simply to denote the differences between large, isolated places and small places of family-scale whose residents interact with the wider community.

person-by-person determinations and will be consistent with Congress' focus upon the elimination of outmoded custodial institutions.

The story of the evolution of Congressional policy regarding state treatment of severely retarded people is as follows.

A. Congressional Encouragement of Community-Based Services

On February 5, 1963, following the findings of his President's Panel on Mental Retardation,[16] President John Kennedy delivered a Special Message to the Congress calling its attention to the "antiquated, vastly overcrowded, chain of custodial state institutions." 1963 *Public Papers of the Presidents* 126, 128; 109 *Cong. Rec.* 1837, 1838 (1963). As to the future, the President's 1963 Message said:

> "[S]ervices to the mentally retarded must be community based. . . . We must move from the outmoded use of distant custodial institutions to the concept of community-centered agencies." *Id.* at 128, 134; 109 *Cong. Rec.* at 1838, 1841.

The Special Message called upon the Congress to legislate:

> "To retain in and return to the community . . . the mentally retarded, and there to restore and re-

16. Among the recommendations of the President's Panel had been: "Improved methods and facilities for care, with emphasis on the home and the development of a wide range of local community facilities." Report to the President, *A Proposed Program for National Action to Combat Mental Retardation* 14 (1962). The President's Panel forewarned:

> "After nearly 200 years of orientation to the concept of congregate care for the mentally retarded . . . , it is difficult to change the pattern and adopt a new frame of reference. As long as we have major financial investments in large plants, it will be a temptation to some to defend them as satisfactory or even preferable." *Id.* at 143.

vitalize their lives through better health programs and strengthened educational and rehabilitation services." *Id.* at 137; 109 *Cong. Rec.* at 1842.

Congress responded by authorizing funds for comprehensive retardation plans [17] and by enacting a new federal-state grant-in-aid program to fund community-based alternatives.[18]

In 1967, Congress expanded federal funding authority to include grants to the states for staffing and start-up expenses of community facilities.[19]

In 1970, Congress replaced these authorities with the Developmental Disabilities Services and Facilities Con-

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17. The Maternal and Child Health and Mental Retardation Planning Amendments of 1963, P. L. 88-156.

18. The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, P. L. 88-164. Under this Act, by 1969, $137.4 million were granted to the states to build community vocational, day care, educational and residential facilities, as well as community service coordination facilities and research and university affiliated training centers—"a network of facilities where the retarded can obtain services in their own communities." Secretary's Committee on Mental Retardation, *Mental Retardation Construction Program* iii (March 1969) reprinted in *Mental Retardation and Other Developmental Disabilities, 1969,* Hearings Before the Subcomm. on Health of the Senate Comm. on Labor and Public Welfare, 91st Cong., 1st Sess. 343, 409 (1969) (hereinafter "1969 S. Hearings").

The Developmentally Disabled Assistance and Bill of Rights Act of 1975, like the three intermediate Congressional enactments in 1967, 1970 and 1973, is formally a Title of this 1963 Act. See *Compilation: Rehabilitation, Comprehensive Services and Developmental Disabilities Legislation,* prepared for the Subcomm. on the Handicapped of the Senate Comm. on Labor and Human Resources (Comm. Print 1979).

19. The Mental Retardation Amendments of 1967, P. L. 90-170, § 4, 81 Stat. 528.

struction Amendments,[20] a broad, new federal-state grant-in-aid program intended (1) to provide funds to the states for "gap-filling" community services, because other statutes, for example, the Social Security Act and the Rehabilitation Act, by now provided the largest portion of federal funds to state retardation services; and (2) to focus the state's use of these other federal funding authorities upon supplying community alternatives to institutionalization by requiring certain state planning mechanisms. See P. L. 91-517, 84 Stat. 1316-21; § 101(b).[21]

In 1973, in order to review the effectiveness of the program, Congress extended the Developmental Disabilities Services Act for only one year. P. L. 93-45; H. R. Rep. 93-227 at 6-7; 1973 U. S. Code, Cong. & Adm. N. at 1469. In 1974 the Act was again extended for a single year.

B. Court Action Before Congressional Direction

In the early 1970's faced with the actuality of custodial institutions presented by the claims of severely retarded people sustaining regression, abuse and injury in them and lacking Congressional direction, a substantial number of lower courts relied on the Constitution to attack two aspects of state treatment of retarded people.

1. *Rights to treatment within institutions*

Wyatt v. Stickney, 344 F. Supp. 387 (M. D. Ala. 1972), *aff'd sub nom. Wyatt v. Aderholt,* 503 F. 2d 1305 (5th Cir.

20. In the 1970 Act, P. L. 91-517, the Congress recognized, as its title shows, the developmental view of severely retarded people. See note 37 *infra.*

MR 68 and *MR 69,* Reports to Presidents Johnson and Nixon of the President's Committee on Mental Retardation, and Congress' Hearings and Reports preceding the 1970 Act provide a retrospective on the decade. See *MR 68: The Edge of Change* 4, 11-12; MR 69: *Toward Progress—The Story of A Decade* 26-27, 30. Both Reports are reprinted in 1969 S. Hearings at 273 and 309. See also S. Rep. 91-757 at 2-3, 9 (April 6, 1970), H. R. Rep. 91-1277 at 13-15 (July 6, 1970).

21. Substantially the same provisions are at 42 U. S. C. §§ 6063 (b)(2), 6067 (1976).

1974) was first.[22] Although *Wyatt* closed admissions to the institution and spoke of least restrictive environments, it basically sought a remedy by providing extensive, detailed standards to improve institutional conditions.[23] *New York State Association for Retarded Children v. Carey*, 393 F. Supp. 715 (E. D. N. Y. 1975) (the *Willowbrook* case) followed.[24] It embraced a different constitutional ground regarding "cruel and unusual punishment" and a right to "protection from harm" and after extensive remedial involvement, the court moved toward a different remedy from *Wyatt*. Its remedial orders directed that "[d]efendants shall take all steps necessary to develop and operate a broad range of non-institutional community facilities and programs to meet the needs of

22. The courts which examined large, isolated institutions found their central destructive effect to be the regression they imposed upon residents. *Wyatt v. Stickney*, 344 F. Supp. 387, 391 (M. D. Ala. 1972) *aff'd sub nom. Wyatt v. Aderholt*, 503 F. 2d 1305, 1309 n. 4 (5th Cir. 1974); *New York State Assn. for Retarded Children, Inc. v. Carey*, 393 F. Supp. 715, 717, 718 (E. D. N. Y. 1975); *cf. Horacek v. Exon*, 357 F. Supp. 71, 73 (D. Neb. 1973).

23. Seven years later, still relying only upon the Constitution, the *Wyatt* court found "substantial and serious non-compliance" with its standards in the Partlow institution, though very many additional dollars were being spent and much new staff had been added. *Wyatt v. Ireland*, C. A. No. 3195-N, unreported opinion of October 25, 1979.

24. It was Senator Javits' first-hand experiences at Willowbrook which caused him to originate the Bill of Rights:

> "I personally viewed the tragedy of Willowbrook. At the request of Governor Rockefeller, I urged special Federal crisis intervention to assist the State of New York in improving the situation at Willowbrook and any other New York State institutions with similar difficulties and pledged myself to the introduction of a bill of rights for the mentally retarded. I regret that the HEW report failed to provide urgently needed Federal leadership to the Willowbrook crisis and the plight of all mentally retarded." 1973 S. Hearings, *infra* note 30, at 230.

Willowbrook's residents and of the class," requiring that within six years the Willowbrook institution be reduced to "250 or fewer" people. 393 F. Supp. at 717.[25] *Willowbrook* is the first case disfavoring institutional placement and ultimately finding that the specific challenged institution could not be made decent or workable.[26]

2. *Right to education within community*

Throughout the country state laws had excluded severely retarded people from the public schools; in direct consequence large numbers of them had been institutionalized.[27] Beginning with *Pennsylvania Association for Re-*

25. The Willowbrook court's first remedial orders were informed by the findings of a 1968 Federal Study Team on Willowbrook that "there [is] an urgent need to develop more community-based facilities as opposed to institutions." S. Rep. 94-160, *infra* note 30, at 30 (1975) (the Senate Report on the Bill of Rights).

In *Horacek v. Exon* (C. A. No. 72-L-299, D. Neb., October 31, 1975) (the *Beatrice* case), the remedy entered was similar, that Beatrice be reduced from 1,200 to 250 or fewer and its residents be provided instead community residences and other community services.

26. After early experience during implementation with transfers to other smaller but still isolated and larger than family-scale institutions, one of 75 people, the court barred such transfers, including transfers to the newly-constructed 250-bed Bronx Development Center, *NYSARC v. Carey,* C. A. No. 72-C-356, 357, E. D. N. Y., slip opinion of June 10, 1977. After successful experience with transfers to structured and supervised family-scale community living arrangements, the court required such for all Willowbrook residents and announced its intention ultimately to order community-based residences for all, *NYSARC v. Carey,* 466 F. Supp. 479, 485 (E. D. N. Y. 1978) (dictum), *aff'd* 612 F. 2d 644 (2d Cir. 1979). See testimony of the Chairman of the court-appointed Willowbrook Review Panel to the district court in this case, 358a-360a.

27. At Pennhurst, 1004a, as in public retardation institutions nationally, the average age of admission has been 14; 80% of institutional residents were admitted when 18 years old or under. Butterfield, "Some Basic Changes in Residential Facilities," in PCMR,

tarded Citizens v. Commonwealth of Pennsylvania, 343 F. Supp. 279, 294-297 (E. D. Pa. 1972) (three judge court), many courts found a constitutional right not to be excluded from public education and invalidated the state laws which had forced severely retarded children out of the community and into institutional placement.[28] *PARC* and the decisions following were predicated upon findings that all severely retarded persons are capable of benefiting in important ways from a properly structured program of education and training.[29]

C. Congress' Directive Statutes

During four legislative years, 1972-1975, Congress held extensive hearings to review the effectiveness of its 1963-1970 incentives, the operation of the wider statutory fabric of disability programs, and the various litigative efforts and court approaches intended to improve the situation of the severely retarded and other developmentally disabled

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27. (Cont'd.)

Changing Patterns in Residential Services for the Mentally Retarded 15, 22-23 (Rev. Ed. 1976). Once in, at Pennhurst as nationally, the average time residents have been there is 21 years. 20a; *id.* at 23.

28. By 1975, forty-six pending or completed court cases concerned constitutional claims of right to education for severely retarded and otherwise handicapped children. See H. Rep. 332, 94th Cong., 1st Sess. at 3-4 (1975); 121 *Cong. Rec.* 19487-19491 (1975) (summary of cases inserted by Senator Williams, Chairman of the Committee on Labor and Public Welfare).

29. The education cases in effect applied the Court's dictum in *San Antonio Independent School District v. Rodriguez,* 411 U. S. 1, 36-37 (1972) that "if a State's . . . system occasioned an absolute denial of educational opportunities to any child" or denied "an opportunity to acquire the basic minimum skills" questions of constitutionality would arise under the guarantees of expression, association and citizenship.

people.[30] To vindicate variously conceived constitutional rights, Congress reached clear conclusions, as follows:

1. *Related Enactments Based Upon the Developmental View of Severely Retarded People*

PARC was clearly endorsed in the Education for All Handicapped Children Act of 1975 and its predecessor Elementary and Secondary Education Amendments of 1974. Congress required that "the State[s] assure all handicapped children[,] regardless of the severity of their handicap[,] the right to a free appropriate public education", 20 U. S. C. § 1412(1) and (2)(C). Congress required that priority in time-phased implementation of a free appropriate public education for all be given "first to handicapped children who are not receiving an education, and second . . . to handicapped children, within each disability, with the most severe handicaps who are receiving an inadequate education." 20 U. S. C. § 1412 (2)(B) and (3).[31] A program of monitoring and enforcement modelled on and enlarging upon the *PARC* example and using the common statutory form of federal-state entitlement programs was enacted; federal courts were

30. Hearings and Reports of the Congress during 1972-1974 on the Developmentally Disabled Assistance and Bill of Rights Act of 1975, the Education for All Handicapped Children Act of 1975 and its predecessor 1974 Elementary and Secondary Education Amendments, the Rehabilitation Act of 1973 and its succeeding Rehabilitation Amendments of 1974, and the White House Conference on Handicapped Individuals Act are compiled in Appendix A to this Brief. They are cited hereinafter by the abbreviated form set out in the Compilation.

31. Congress found:

"developments in the training of teachers and in diagnostic and instructional procedures and methods have advanced to the point that given appropriate funding, state and local educational agencies can and will provide effective education and related services to meet the needs of handicapped children." P. L. 94-142, § 3(a), 89 Stat. 774, 20 U. S. C. § 1401 note.

See 20 U. S. C. §§ 1431(a)(3)(B) and 1414(a)(6).

clearly directed to ensure that this Act is complied with by the states, 20 U. S. C. § 1415(e) (1976). It was plain that Congress intended to exercise its enforcement powers under Section 5 of the Fourteenth Amendment, see e.g., H. R. Rep. 94-332 at 2-4 (1975); S. Rep. 94-168 at 6, 9 (1975); P. L. 94-142, § 3(a) 89 Stat. 774-75, 20 U. S. C. § 1401 note, and that Congress was legislating to reach and to render unnecessary the institutionalization of severely retarded persons:

> "Providing educational services will ensure against persons needlessly being forced into institutional settings. One need only look at public residential institutions to find thousands of persons whose families are no longer able to care for them and who themselves have received no educational services. Billions of dollars are spent each year to maintain persons in these subhuman conditions." S. Rep. 94-168 at 9 (1975).[32]

2. *Section 6010's Application of the Developmental View to Residential Programs*

In Section 6010 of the Developmentally Disabled Assistance and Bill of Rights Act of 1975 the Congress addressed residential programs for the severely retarded:

(a) *Substantive Residential Program Standards*

Congress in Section 6010 rejected the *Wyatt* approach of extensive detailed standards focused on the goal of improving programs in large, isolated institutions. In § 6010, Congress embraced a different standard: that state residential programs "should be designed to maximize the developmental potential" of every severely retarded per-

32. As to adult severely retarded people, Congress in the Rehabilitation Act of 1973 completely revised the vocational rehabilitation program to require that vocational rehabilitation shall "serve *first* those with *the most severe handicaps.*" 29 U. S. C. §§ 701(1), 721(a)(5)(A) (emphasis supplied).

son and that this design could best be accomplished in small-scale (i.e., family-styled), community-based residences (i.e., in the language of the statute, "in the setting that is least restrictive of . . . personal liberty").[33] Throughout the Hearings, testimony upon testimony showed such a design to be practical and feasible in family-scale community residences, (e.g., 1973 S. Hearings at 246-

33. Section 6010 emerged from Conference Committee as a succinct expression of the essential elements of the Senate's 328-page bill of rights, 121 *Cong. Rec.* 16470-16514 (1975), eschewing enactment into positive statutory law of extensive detailed standards for the operation of residential and other programs in favor of setting "the direction and framework for improving the overall situation of this country's mentally retarded". 121 *Cong. Rec.* 29820 (1975) (chief sponsor); *id.* at 29818 (Chairman, Subcomm. on the Handicapped); *id.* at 29821 (Chairman, Comm. on Labor and Human Resources).

For the long-form statement of the rights encapsulated in Section 6010, see S. 462 (1975) at, *e.g.* § 221(a)(b) ("accessible to the community"), § 215(8) ("family or home-like . . . conducive to achievement by the resident"), § 249(a) ("small enough to insure . . . meaningful . . . personal relationships") and §§ 220-283 (administrative policies and practices, services, records, safety and sanitation).

The desire for simplicity in statement of the rights (121 *Cong. Rec.* 29309 (1975)), the concern expressed frequently at Hearings that lengthy detailed standards might mistakenly reinforce the maintenance of large residential institutions thus defeating the bill's central purpose (see, e.g., 1973 S. Hearings at 242-43; 245-46; 323-25 and 645, 1974 H. R. Hearings at 1052-53, 1055), and the desire to avoid a complexity which would prejudice court enforcement (H. Conf. Rep. 94-173 at 42; 1975 U. S. Code, Cong. & Adm. N. at 943, 961), contributed to the precise formulation of § 6010.

The House had relied on an earmarking provision in its program assistance bill to induce the rebudgeting of state and other federal funds currently spent on institutional care to community care instead, H. Rep. 94-58 at 10; 1975 U. S. Code, Cong. & Adm. N. at 928; 121 *Cong. Rec.* 9977 (1975). Section 6010 thus required directly of all institutions or residential programs receiving public funds what the House bill had sought to encourage.

47; 256-57; 323-25; 345; 348; 562-63; 692-93); at no point is there identified or described, as a matter of fact or theoretically, any large institution so designed or any individual whose disabilities could possibly require a large isolated institution.[34] Congress instead concluded:

> "It must be recognized that the vast majority of developmentally disabled persons and the vast majority of persons now institutionalized should not be in these institutions at all. Efforts to assure proper treatment, education, and habilitation services in large institutions should not deflect attention from the fact that *most of these institutions themselves are anachronisms, and that rapid steps should be taken to phase them out.* Many of these institutions by their very nature, their size, their isolation, their impersonality, are unsuitable for treatment, education, and habilitation programs." S. Rep. 94-160 at 32-33 (emphasis supplied).[35]

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34. Congress was explicitly attentive to the fact that phasing out offending institutions would not occur overnight and was concerned to assure some minimum attention to safety and decency, consistent with the constraints large, isolated institutions impose, for those who would for any time more be in them. *E.g.*, S. Rep. 94-160 at 32; see testimony of NARC, 1974 H. R. Hearings at 1052-53; 1974 S. Hearings at 389. Hence Section 6010(3)(B)(*i-vi*).

35. The Chairman of the Senate Labor and Public Welfare Committee, closing floor consideration of the Bill of Rights in the Senate, rendered this appraisal:

> "Over the past few years, the horrifying conditions which exist in most of the public residential institutions for the mentally retarded and other developmentally disabled persons have provided shocking testimony to the inhuman way we care for such persons. The conditions at Willowbrook, at Partlow in Alabama. and at Rosewood in Maryland, and at many other institutions have shown beyond a shadow of a doubt that the treatment of these individuals is worse than all of us would like to admit.
>
> "Steps to scale down many of these large custodial institutions have resulted in not-so-large institutions, often with not

Throughout its deliberations the Congress emphasized and re-emphasized:

> "the tragic lack of developmental services which enable most individuals with developmental disabilities to, in fact, live more normal lives." S. Rep. 94-160 at 36.

Throughout it reiterated:

> "all persons with developmental disabilities have the right to services and treatment which will promote their development and enable them to live in the community, whether or not that entails a protected environment."

By requiring "treatment, services and habilitation", the Congress thus flatly rejected custodial care.[36] Congress did not prohibit all large isolated institutions; it

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35. (Cont'd.)

much improved care and with little followup. This has been true of Willowbrook: in 1965 and again in 1972, broad criticism has been levied at this institution; all indications point toward little change, unless substantial legal advocacy pressure is forthcoming. While much can be said about the lack of available funds to improve conditions at these institutions, at some point this country must draw the line. The abuses are too commonplace to point at a single institution, or a single abuse and say that it is an anomaly." 121 *Cong. Rec.* 16516-17 (1975)."

36. Petitioners make only one argument as to the "substance of the obligations" established by Section 6010(1)(2) and (3). Br. 26. The argument isolates subsection (3) and then asserts "the section requires facilities to provide appropriate treatment *'or'* to comply with six specific criteria; hence its terms can be satisfied in *either* fashion." The juxtaposition of this argument just with the language of subsection (3) shows it to be wrong as a matter of plain meaning:

prohibited custodial institutions, and allowed the pos-

36. (Cont'd.)

Section 6010:

(3) The Federal Government and the States both have an obligation to assure that public funds are not provided to an institution or other residential program for persons with developmental disabilities that—

(A) does not provide treatment, services, and habilitation which is appropriate to the needs of each person; or

(B) does not meet the following minimum standards: (i)-(vi).

Petitioner's reading:

The section requires facilities to provide appropriate treatment *"or"* to comply with six specific criteria; hence, its terms can be satisfied in *either* fashion.

Plainly the subsection means that public funds may *not* be provided to facilities that either do *not* provide appropriate treatment or do *not* comply with six specific criteria. To receive public funds a facility must satisfy both requirements; it must both provide appropriate treatment *and* comply with six specific crtieria.

The source of Petitioners' mistake is revealed by their adoption (Br. 26 n. 45) of a district court's holding in *Kentucky Assoc. for Retarded Citizens v. Conn,* (C. A. No. C-78-0157 LA, W. D. Ky), unreported Slip Opinion of March 21, 1980. Petitioners explain that a facility which satisfies *either* requirement may lawfully be funded by quoting that opinion as follows:

> "It would seem that Congress realized that there might even be situations where a developmentally disabled person would not have to be furnished treatment and habilitation as such, but would have to be provided with *custodial care* according to minimum standards such as proper diet, appropriate medical services, proper safety compliance, and prohibition of the use of physical restraints." (emphasis supplied)

It could not be clearer that Section 6010 was enacted by the Congress precisely to reject *custodial care,* to forbid it, and instead to require appropriate treatment, services and habilitation for every severely retarded person.

sibility that some large isolated institution might accommodate a potential-maximizing design. But Congress clearly accepted the overwhelming testimony before it, the evidence of history, the experience of retarded people, retardation professionals and organized parents, and its own observations that such institutions were most unlikely. Thus Congress adopted a strong presumption in favor of family-scale community-based residential settings and against large, isolated institutions intending that this presumption can be rebutted only by demonstrating that any given large, isolated institution is in fact maximizing developmental potential. The burden upon the State to so demonstrate is a heavy one, for the Congress had found large, isolated institutions to be commonly and persistently offensive, defeating the developmental potential of severely retarded people.[37]

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37. Plainly Congress based the Education Acts of 1974 and 1975, the Rehabilitation Act of 1973 and Section 6010 itself in the developmental view of severely retarded people and has required the states to act upon this view. The Senate Report accompanying the Bill of Rights articulates the developmental view as well as contending traditional views which the Congress rejected; in part S. Rep. 94-160 at 27-28 says:

> ". . . . Finally, there is the view that developmentally disabled individuals are 'diseased.' They are viewed as sick and in need of constant care. This leads to indefinite custodial care. This last model is gradually being replaced by a *developmental view* of mental retardation. Such a view stresses that *all developmentally disabled individuals have potential for learning and growth.*
>
> "From this developmental model, it follows that *custodial care*—which is predicated on *the assumption that certain individuals are essentially incapable of development—must be rejected.* The newer developmental model emphasizes concrete program goals for individuals and therefore encourages evaluation based on specific outcomes.

(b) *Federal Funding Governed by Section 6010*

Section 6010 makes clear that this substantive programmatic standard applies to all public funds for institutional or residential programs. Federal monies thus governed by Section 6010 include not just those under the program assistance provisions of the Developmental Disabilities Act, but the full range of funds across the entire statutory fabric of federal-state programs for retardation services: at least $3.168 billion in federal funds in fiscal year 1980. U. S. Department of Health, Education and Welfare, *Special Report: Mental Retardation* in *Hearings before the Subcommittee on Departments of Labor, HEW, and Related Agencies of the Committee on Appropriations,* 96th Cong., 2d Sess., pt. 2 at 641-44, 673.[38]

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37. (Cont'd.)

"*A final, but critically important dimension of this new model is that developmentally disabled persons should live like nondevelopmentally disabled persons to the greatest degree possible.* Every effort should be made to assist developmentally disabled persons to maximize their ability for self-care and to live normal lives. From this, it also follows that each developmentally disabled person should be allowed to live in the least restrictive environment conducive to his or her maximum development."

See also the White House Conference on Handicapped Individuals Act of 1974, 88 Stat. 1631-34 § 301(b), 29 U. S. C. § 701 note (1976).

38. The Report's "total obligations" line is arithmetically correct through page 643; the expression of education expenditures (644) as $184,000, rather than $184 million (as 673 shows them), requires a correction in the total obligation line on 644, to the textual figure.

The 1980 HEW Report shows HEW expenditures for retardation for each fiscal year since 1977. It understates HEW expenditures, for it does not report social service (title XX) or medical assistance expenditures (see page 660). It does not include expenditures by other departments, e.g. by HUD, e.g. 42 U. S. C. § 1438, by Labor, 29 U. S. C. §841 *et seq.*, or by Treasury, 31 U. S. C. § 1221 *et seq.*

The federal share under these federal-state assistance programs varies: for Vocational Rehabilitation expenditures it is 80%, 29

By far the largest amount of federal funds to state retardation services flow to adult services; in particular, the largest single portion is Title XIX (ICF/MR), which can be used to support community-based residential facilities of 4 to 16 persons. 42 U. S. C. § 1396d(d).[39] Title XIX is an entitlement program—a state must serve every eligible individual who wants the service provided under the Act and the federal government will bear a portion of the cost, in Pennsylvania 56%. 42 U. S. C. § 1396a(a)(8).[40] Every person who is a beneficiary of the rights established by Section 6010 is also eligible for Title

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38. (Cont'd.)
U. S. C. § 706(6) (Supp. 1978); Title XX social services, 75%, 42 U. S. C. § 1397a(a) (Supp. 1978); for Title XIX residential and related services, 50 to 83%, 42 U. S. C. § 1396d(b) (Supp. 1978).

39. In 1971 Congress amended the long-term care residential service provisions of Title XIX to authorize residential service funding for: "the active provision of rehabilitative, educational and training services to enhance the capacity of mentally retarded individuals to care for themselves or to engage in employment," 117 *Cong Rec.* 44720 (1971) (chief sponsor). 42 C. F. R. § 435.1009 and, e.g., § 442.481(g) (1979). See also U. S. Dept. HEW, H.C.F.A. "Interpretive Guidelines and Survey Procedures for the Application of the Standards for Institutions for Mentally Retarded Persons or Persons With Related Conditions" (September 5, 1974).

40. The entitlement terms of Title XIX are precisely the same as the terms of Title IV of the Social Security Act (A.F.D.C.), enforced by the Court against the states in, e.g. *King v. Smith*, 392 U. S. 309, 333 (1968); *Townsend v. Swank*, 404 U. S. 282, 286 (1971), and *Carleson v. Remillard*, 406 U. S. 598 (1972).

Unlike Title XIX, funds for vocational rehabilitation and education programs do have ceilings; but the Rehabilitation Act directs: "*in the event* that the vocational rehabilitation services *cannot* be provided to *all* eligible handicapped individuals . . . , selection . . . shall be determined on the basis of serving *first* those individuals with the *most severe* handicaps." 29 U. S. C. § 721(a)(5)(A) (emphasis supplied).

XIX residential services.[41] Thus a state which accords severely retarded people the residential services required by Section 6010 may obtain federal financial support for 50% to 83% of the cost.

Far from imposing an unbearable burden on the states and leaving them fundless to discharge their statutory obligations under Section 6010 (Pet. Br., *passim*), the integrated statutory scheme of which Section 6010 is the paramount provision, fairly and fully shares the cost of implementing the rights of severely retarded people, provided only the states are scrupulous in respecting their rights and focusing services to them upon community-based programs.

c. *Judicial Standards for Enforcement of Section 6010*

Congress did not mean to abandon the example of judicial action to protect the severely mentally retarded; it did not abandon *Wyatt, Willowbrook, PARC* et al. in this regard. To the contrary, Congress understood and intended that "to change the tragic warehousing . . . that has been the product of insensitive federal support of facilities providing inhumane care and treatment . . .", 121 *Cong. Rec.* 16519 (1975), would require judicial enforcement of Section 6010.[42] But by providing clear standards for the judiciary to apply, Congress remedied the problem in the earlier cases that judges were left at large to weigh conflicting opinions and contending views regarding severely retarded people and the ways and means of appropriate treatment of them. Congress has much greater competence to make such decisions than

41. "[T]he mentally retarded or persons with related conditions" are eligible for ICF/MR services. 42 U. S. C. § 1396d(d). From the beginning and now, the definition of retardation and related conditions under Title XIX (ICF/MR) has been "developmental disabilities, as defined under [the D. D. Act], as amended." 42 C. F. R. § 435.1009 (1979); 39 *Fed. Reg.* 2223 (January 17, 1974).

42. On the enforceability of § 6010 in a private right of action, see Argument II below.

courts and, regarding the severely retarded, the Congress has made those decisions.[43] With Section 6010, the courts need no longer be so troubled nor need they try each institution presented to the court by the claims of severely retarded people *ab initio* without direction from the Congress; now the judicial task is the customary one, as to which court competence is undoubted: application of the Congressionally-set standards to particular cases.

D. The Application of Section 6010 to This Case

Judge Broderick's ruling that Pennhurst must be closed appeared to the Third Circuit as an application of a *per se* rule that no institution under any imaginable program could pass muster. If Judge Broderick in fact meant to apply such a *per se* rule, he would have been misapplying Congress' intention concerning large, isolated institutions, by transforming the Congress' strong but rebuttable presumption into a conclusive one. The Third Circuit was clearly faithful to the statute when it held:

> "Of course, deinstitutionalization is the favored approach to habilitation. The federal statutory materials make that clear. . . . However, we have recognized that although institutionalization is strongly disfavored, it is not foreclosed by the governing federal and state statutes." (158a-159a).[44]

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43. By contrast Congress has not acted regarding mentally ill people with such specificity and has not, as it did in Section 6010 for retardation programs, defined the standard which must govern judicial review of state actions regarding the mentally ill. Thus the Court's caution in *Parham v. J. R.*, 442 U. S. 584 (1979) and *O'Connor v. Donaldson*, 422 U. S. 563 (1975) regarding the treatment of mental illness is justified but not applicable here.

44. Also reflecting exactly the fabric of the Congressionally set standard, the Court of Appeals wrote:

> "It is probably true, as the trial court found, that in general institutions are less effective than community living arrangements in facilitating the right to habilitation in the least restrictive setting. There is ample testimony on the record indicating

But the Third Circuit also specified that the district court should make person-by-person judgments regarding individual placement (e.g., 156a, 159a-160a). This is inconsistent with the Congress' intent that courts judge the validity of particular state residential programs, not that courts make individual placement decisions with respect to those programs. This may also not be consonant with the concern expressed by the Court in *Parham v. J. R., supra,* regarding the competence of federal judges to make individual placement decisions[45]; whereas judges are clearly competent to review state administrative and professional judgments regarding the purposes and actual effect of their residential *programs,* as in general agency reviews. *Parham* itself envisions that the programmatic adequacy of professional admissions decisions is to be judicially reviewed, to assure adequate professional "independence." 442 U. S. at 617.[46]

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44. (Cont'd.)

the shortcomings of institutions as places for habilitation. . . . Moreover, institutions would generally appear not to be the least restrictive environment in which to provide habilitation." (155a-156a).

45. But see *O'Connor v. Donaldson,* 422 U. S. 563, 574 n. 10 (1975) where Justice Stewart wrote for the Court:

> "O'Connor argues that . . . the Court must assume that Donaldson was receiving treatment sufficient to justify his confinement, because the adequacy of treatment is a 'nonjusticiable' question that must be left to the discretion of the psychiatric profession. That argument is unpersuasive. Where 'treatment' is the sole asserted ground for depriving a person of liberty, it is plainly unacceptable to suggest that the courts are powerless to determine whether the asserted ground is present. See *Jackson v. Indiana,* 406 U. S. 715. . . ."

46. In *Parham,* this Court ruled that states need not require state court judges to examine or override decisions by parents to place their children in psychiatric facilities when that decision was supported by the independent judgment of qualified professionals. In this case Judge Broderick was not overriding such joint decisions

It is not clear that Judge Broderick did in fact apply an impermissible *per se* rule. He had an extensive record before him about every aspect of the Pennhurst institution. He had extensive experience regarding the severely retarded, dating from his participation as a member of the *PARC* court, see p. 20 *supra*. He was very aware of his limitations as a judge regarding inappropriate interference with professional judgment. In his dissent to the district court decision in *Institutionalized Juveniles v. Sec. of Public Welfare*, 459 F. Supp. 30, 50 (1978), which was specifically cited with approval by Chief Justice Burger for the Court, reversing, in *Secretary v. Institutionalized Juveniles*, 442 U. S. 640, 645 n. 7 (1979), Judge Broderick had written: "the determination as to the kind of education, training and care which will be most beneficial to the retarded juvenile is a decision more appropriately left to the professionals outside the judicial process." What appeared to the 3d Circuit as the application of a *per se* rule, may more correctly be seen as the application of exactly the presumption Section 6010 embodies and a judgment on the extensive record before him as to Penn-

46. (Cont'd.)

by parents and independent professionals. He was instead relying on the overwhelmingly expressed judgment of professionals, including the defendants' own professional witnesses, that no child should ever be sent to this particular institution, Pennhurst. In doing so, Judge Broderick was enforcing the mandate of this Court in *Parham* to ensure retardation professionals' "independent . . . neutral and detached . . . judgments . . . in the best interest of the children", (442 U. S. at 616-17).

Judge Broderick's remedial Order here, para. 2, 80a, placed individual program plan decisions where they ordinarily belong, in the county and state process. Since on the record such decisions had not heretofore been made in accordance with professional standards, the district court ordered they be so made and for the first time required that parents or next relatives and retarded persons themselves be given a full opportunity to participate in the individual program plan process. Because of the record, the district court appointed a special Master to review the process as to professional adequacy.

hurst, that the burden of rebuttal had not been met, that this particular institution could not conceivably meet the standards mandated by Congress so that alternative family-scale, community-based residential programs have to be provided.[47]

This Court should affirm Judge Broderick's judgment concerning the failure of state officials to satisfy the Section 6010-imposed burden of proof necessary to justify Pennhurst, on the ground that this record and the clear competence and care Judge Broderick brought to his judgment met the statutory criteria. Alternatively, the Court could remand to Judge Broderick for clear statement by him regarding the standard he was applying. Either course—affirming Judge Broderick or remanding—would affirm the Third Circuit's judgment regarding the institutional program standards in Section 6010, but would modify that court's misreading, when it required individual-by-individual judicial determinations, of the intention of Congress. Congress clearly did intend that courts inquire into a residential program itself applying a presumption against large, isolated institutions. This inquiry was conducted by the district court and the Third Circuit erred in disallowing it and its remedial consequences.[48]

II. The Personal Rights and Entitlements Established by Section 6010 Are Enforceable in the Federal Courts

This Court in *Maine v. Thiboutot,* 100 S. Ct. 2502 (1980), held that 42 U. S. C. § 1983 provides a remedy to enforce, as against official deprivations, rights established by any federal statute, apparently including Section 6010. Petitioners argue the exception, that exclusive remedy for violations of Section 6010 lies with the Secretary of Health

47. This view of Judge Broderick's decision, fully supported on the record of the case and in the district court's opinion, is discussed at Argument IV below.

48. It was to support this conclusion that respondents' PARC et al. filed the conditional cross-petition in No. 79-1414.

and Human Services;[49] they argue also that judicial relief available to severely retarded people is limited to an injunction to cut off federal funds and may not encompass enjoining the official violation of federally protected statutory rights. Both arguments are contrary to the settled course of this Court's decisions.

A. Exclusive Enforcement of Section 6010 Has Not Been Granted the Secretary of HHS

Congress did not confide exclusive enforcement of Section 6010 to the Secretary of HHS, any more than it did in the statutes declaring personal rights examined in *Cannon v. University of Chicago,* 441 U. S. 677, 704-08 (Title IX); in *Regents of University of California v. Bakke,* 438 U. S. 265, 419 n. 26 (1978) (Stevens, J., for Burger, C. J., Stewart and Rehnquist, J. J., dissenting in part and concurring in part) (Title VI);[50] in *Lau v. Nichols,* 414 U. S.

49. "The only exception," Mr. Justice Powell wrote, dissenting in *Maine,* "will be in cases where the governing statute provides an exclusive remedy for violations of its terms." *Id.* at 2513, n. 11.

Mr. Justice White, in *Chapman v. Houston Welfare Rights Organization,* 441 U. S. 600, 672 (1979) (concurring), had written:

> "The substantive scope of the rights which may be protected and vindicated under § 1983 against contrary state action . . . includes not only federal constitutional rights but also all rights secured by federal statutes unless there is clear indication in a particular statute that its remedial provisions are exclusive or that for various other reasons a § 1983 action is inconsistent with congressional intentions."

50. "The notion that a private action seeking injunctive or declaratory judgment relief is inconsistent with a federal statute that authorizes termination of funds has clearly been rejected by this Court in prior cases. See *Rosado v. Wyman,* 397 U. S. 397, 420. . . ." *Bakke, supra* at 419, n. 26.

Mr. Justice Stevens for the Court in *Cannon, supra* at 690 n. 13, wrote that the Court has long "recognized the propriety of inferring a federal cause of action for the enforcement of civil rights, even when Congress has spoken in purely declarative terms."

563, 565 (1974) (Title VI); or in the federal-state grant-in-aid statutes requiring certain conduct of the states, *Rosado v. Wyman,* 397 U. S. 397 (1970) and its progeny.

In *Rosado v. Wyman,* 397 U. S. 397, 420 (1970), Mr. Justice Harlan had written for the Court:

> "We have considered and rejected the argument that a federal court is without power to review state welfare provisions or prohibit the use of federal funds by the States in view of the fact that Congress has lodged in the Department of HEW the power to cut off federal funds for non-compliance. We are most reluctant to assume Congress has closed the avenue of effective judicial review to those individuals most directly affected by the administration of its program." [51]

Not only is the "clear indication in [the] statute that its remedial provisions are exclusive" *Chapman v. Houston Welfare Rights Organization,* 441 U. S. at 672, entirely absent in the Bill of Rights Act but there is not a hint anywhere in the extensive legislative history of Sec-

51. *Rosado* noted as to public assistance recipients:

"Petitioners do not seek review of an administrative order, nor could they have obtained an administrative ruling since HEW has no procedures whereby welfare recipients may trigger and participate in the Department's review of a welfare program." 397 U. S. at 406.

The same is true here. Section 45 C. F. R. § 1386.94(b)(1) which Petitioners urge "allows for meaningful participation by concerned individuals" in administrative terminations of funding (Br. 31-32) has, in exactly the same form, since 1971, governed compliance hearings under Title IV of the Social Security Act (A. F. D. C.), see 45 C. F. R. § 213.15 (1979), and under Titles XIX and XX, see 45 C. F. R. §§ 201.6, 228.19 (1979). Presence of this provision has never justified curtailment of access to judicial relief. Under it, as under the equivalent provision at the time of *Rosado,* 45 C. F. R. § 201.5(d) (1970), respondents cannot trigger any administrative proceedings and have no more opportunity to participate in Secretarially initiated hearings.

tion 6010 that the long involvement of federal courts in protecting the rights of disabled persons was to be suddenly abandoned at this juncture. To the contrary, the legislative history is replete with Congressional recognition of the vital role of court enforcement. The Conference Report on the Bill of Rights says:

> " These rights . . . should be *protected* and *assured by* the Congress and *the courts.*" H. R. Conf. Rep. 94-473 at 42; [1975] U. S. Code Cong. & Adm. N. 943, 961. (emphasis supplied).[52]

Upon floor consideration, the Chairman of the Senate Labor and Public Welfare Committee had said: "all indications point toward little change unless substantial legal and advocacy pressure is forthcoming." 121 *Cong. Rec.* 16516-17 (1975).

An intention to depart from a pre-existing pattern of court enforcement for an exclusively administrative scheme could be expected to appear somewhere in the record; it does not. It is unlikely that Congress would have relied exclusively upon secretarial enforcement after the Secretary of HEW gave express warning that HEW would not be able effectively to enforce a Bill of Rights. See letter of the Secretary of HEW to Senator Javits, December 11, 1974, in 1975 H. R. Hearings at 167. It is unlikely that a Congress which legislated "to change . . . the insensitive federal support . . . [of warehousing]," 121 *Cong. Rec.* 16519 (1975), intended to confide exclusive enforcement to the Secretary. It is unlikely that a Congress which required each state to establish an independent protection and advocacy system with authority to pursue *legal* remedies, 42 U. S. C. § 6012, intended to confide exclusive enforcement to the Secretary.

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52. That "these rights . . . should be protected and assured by the *Congress* . . ." is plainly a reference to the Congress' exercise of its Section 5 powers to enforce the Fourteenth Amendment. Nor does anything in the legislative history suggest, as Petitioners do (Br. 33 n. 52), that court enforcement was to be limited to "other statutes".

B. Relief for Violations of Section 6010 Is Not Limited to Enjoining Federal Funding

Petitioners argue the sole judicial remedy to enforce Section 6010 is an injunction to terminate federal funding and that any relief to enjoin compliance with the personal rights and entitlements granted by Section 6010 offends interests of federalism and of equity.

Section 6010 is grounded in two plenary Congressional powers, the power to ensure that federal funds are spent as it intends and the power to enforce the rights secured under the Fourteenth Amendment. The Court has held in several decisions that statutes well based in those powers raise no questions of federalism. As to Section 5, *Fitzpatrick v. Bitzer,* 427 U. S. 445 (1976); *cf. Milliken v. Bradley,* 433 U. S. 267, 291 (1977). As to the spending power, *North Carolina ex rel. Morrow v. Califano,* 435 U. S. 962 (1978); *Helvering v. Davis,* 301 U. S. 619 (1937).

Section 6010 is well based in both powers. Throughout its deliberations on Section 6010 the Congress specifically articulated its intention to enforce the Equal Protection Clause. *E.g.,* S. Rep. 94-160 at 32 (1975); 121 *Cong. Rec.* 16519 (chief sponsor), 16515 (Chairman, Subcomm. on the Handicapped), 16516 (ranking minority member, Subcomm.). In Section 6010, the Congress acted to remedy the "life segregation," S. Rep. 94-160 at 27, to which state institutions have subjected severely retarded people, to eliminate historic and deeply intractable barriers to their equal citizenship, and to supply some of its necessary conditions.

Whether Congress' enactment is viewed as overcoming state-imposed segregation of retarded people, *Meyer v. Nebraska,* 262 U. S. 390, 401-02 (1923),[53] or state-imposed

53. There the Court reviewed ancient advice:

"For the Welfare of his Ideal Commonwealth, Plato suggested a law which should provide: 'That . . . the offspring of the inferior, or of the better when they chance to be deformed, will be put away in some mysterious, unknown place, as they should be.' "

but itself concluded:

conditions which deny the opportunity to learn basic minimum skills, *San Antonio Independent School District v. Rodriguez,* 411 U. S. 1, 36-37 (1972),[54] or as enforcing the right to personal security, *Ingraham v. Wright,* 430 U. S. 651, 673 (1977),[55] or the right to a commitment whose nature and duration bear some reasonable relationship to its purpose, *Jackson v. Indiana,* 406 U. S. 715, 738 (1972) or the right of non-dangerous individuals to live safely in freedom with the help of family and friends, *O'Connor v. Donaldson,* 422 U. S. 567, 576 (1975), Section 6010 was a proper exercise of the Congress' power under Section 5 of the Fourteenth Amendment to "impos[e] on the States a remedy for the denial of equal protection that elaborated upon the direct command of the Constitution." *Oregon v. Mitchell,* 400 U. S. 112, 296 (1970) (Stewart, J., concurring); *Katzenbach v. Morgan,* 384 U. S. 641 (1966).

Section 6010 also imposes a paramount framework to direct the use of several substantial federal funding programs for retardation services. See, e.g., Section 204 of the Bill of Rights, P. L. 94-103, 42 U. S. C. § 6010 note. The Court has long held that statutes directed to both federal and state governments to bring order into federal assistance programs do not offend concepts of federalism:

> "When money is spent to promote the general welfare, the concept of welfare or the opposite is shaped by

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53. (Cont'd.)

". . . their ideas touching the relationship between individual and state were wholly different from those upon which our institutions rest; [no] Legislature could impose such restrictions upon the people of a State without doing violence to both the letter and spirit of the Constitution."

54. See the discussion of the *PARC* cases at pp. 19-20 *supra.*

55. Where Mr. Justice Powell for the Court also observed: "The openness of the public school and its supervision by the community afford significant safeguards against the kinds of abuses from which the Eighth Amendment protects prisoners." 430 U. S. at 670.

> Congress, not the states." *Helvering v. Davis,* 301 U. S. 619, 645 (1937) (Cardozo, J.).

See also this Court's decision last Term in *North Carolina ex rel. Morrow v. Califano,* 435 U. S. 962, 98 S. Ct. 1597 (1978) (mem.), *summarily affirming* 445 F. Supp. 532 (E. D. N. C. 1977) (three judge court).[56]

Here, federal contributions to retardation services are so large (more than $3.168 billion in fiscal 1980, see p. 28 *supra*), the requirements of Section 6010 are so closely pertinent to the activities supported by the several federal funding programs for retardation services, and the enactment of Section 6010 was occasioned by such an extremely serious and pervasive national problem touching each of the federally funded programs that there can be no question but that Section 6010 is a proper exercise of Congress' spending power.

As to equitable considerations, certainly a court *may* enjoin the use of federal funds unless a state complies with statutory requirements,[57] but it is not the only permissible

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56. The Court there upheld the National Health Planning and Resources Development Act of 1972, 42 U. S. C. § 300k *et seq.*, as a proper and binding exercise of Congress' spending power, notwithstanding it requires as a condition of federal funds conduct of state officials which violates the North Carolina constitution.

The National Health Planning Act upheld in that case as addressing a matter of vital national interest—hospital cost containment—tracks Section 1122 of the Social Security Act, 42 U. S. C. § 1320a-1, an earlier and continuing hospital construction review provision. Section 1122 requires the states to apply the criteria set forth in the Mental Retardation Facilities and Construction Act of 1963, thus bringing to bear the requirements of Section 6010, for as note 18 *supra* shows, the Bill of Rights Act is a title of that 1963 Act.

57. Almost without question such an injunction would be an effective remedy to change official state and county behavior in this case since Pennsylvania, in fiscal year 1976, e.g., received $7.9 million in federal funds for Pennhurst itself (title XIX), $13.8 million for social services by the counties (title XX), as well as $661,705 in DD Act funds; altogether Pennsylvania's state-county retardation system

remedy. Given a violation of personal rights established by a federal statute, a court applying equitable considerations in adopting a feasible and effective remedy may also choose instead to enjoin future violations of the statute in order to end the violation and directly to achieve the statutory purpose, rather than cut off federal funds. See *Regents of University of California v. Bakke,* 438 U. S. at 419 n. 26; *Cannon v. University of Chicago,* 441 U. S. at 704-708. Fund cut-off is a severe and disruptive remedy of "last resort," *Cannon, supra* at 705 n. 38, which may not serve the interests of the benefited class or the statutory purpose of effectuating their personal rights.[58]

Rosado v. Wyman, supra, is not, as the Court recognized in *Cannon* and *Bakke, supra,* to the contrary. In *Rosado,* the Court did not say that federal fund-cut-off and declaratory relief is the "only" judicial relief to which plaintiffs were entitled. (Pet. Br. at 35) Nor is it correct (Pet. Br. 36, n. 56) that "the Court has not deviated" from the supposed "*Rosado* approach in subsequent cases." Where the only matter at issue is enforcement of a requirement of federal-state grant-in-aid program, the Court has not barred injunctions to end the violation itself.[59] Moreover, when personal rights are at issue, as

57. (Cont'd.)

received some $94 million in federal funds in 1976. PARC Ex. 65, 1039a-40a, 1044a. The federal contribution to retardation services in Pennsylvania is very much larger for fiscal 1980. See *Pa. Governor's Executive Budget* 1979-1980 at 634.

58. In this case where the cost of complying with the requirements of Section 6010 by supplying communtiy residences and other services for each person was found to be less than the offending institutional program, 44a, and where the state has expressed no wish to give up massive annual federal funds for its retardation service programs, the lower courts acted within the bounds of sound equitable discretion in directly enjoining the offensive official conduct and requiring complying conduct.

59. In *Carleson v. Remillard,* 406 U. S. 598, 600 (1972), where a district court had enjoined the state from continuing to use an

here, the Court has consistently treated as proper an injunction directly requiring complying conduct even though there exists the alternative to enjoin the flow of federal funds to the offending institution. *Cannon* supra; *Bakke* supra; *Lau,* supra.

III. Both Courts Below Correctly Held That the State Statute Supports the Judgment in This Case

Pennsylvania's Act of October 20, 1966 was the first legislative response by any state to the 1963 Presidential and Congressional initiative. The Act expressly provides:

> "The department shall have the power and its duty shall be: (1) to assure within the State the availability and equitable provision of adequate . . . mental retardation services for all persons who need them . . ." Pa. Stat. Annot. Tit. 50, § 4201 (225a-226a). See also § 4301 (227a-228a).

As both lower courts held and the structure of the statute, its language and its legislative history show [60], this state

59. (Con'td.)

attribution-of-income regulation which violated the AFDC provision of the Social Security Act, this Court unanimously affirmed without any question the form of the relief below. In *Townsend v. Swank,* 404 U. S. 282, 284 n. 2 (1971), where public assistance recipients sought an injunction against termination of their benefits and the district court denied any relief, the Court unanimously reversed on the merits with no instruction barring relief in the form requested. On remand, the district court directly enjoined state officials from enforcing the offending state law and to furnish benefits to those eligible as a result of the Court's decision, see *Townsend v. Edelman,* 518 F. 2d 116, 119 (7th Cir. 1975). See also *Hagans v. Lavine,* 415 U. S. 528, 533 n. 4, 539 n. 6 (1974) and the three cases cited and apparently approved there, in each of which the offending state conduct was directly enjoined; and see *Carter v. Stanton,* 405 U. S. 669, 670 (1972), *on remand,* 355 F. Supp. 1337, 1338 (S. D. Ind. 1972).

60. The legislative history of the 1966 Act, made entirely by the Act's chief sponsors, is set forth in Appendix A to the blue Brief in Opposition of PARC et al. to the Petitions for Certiorari herein.

statute was enacted exactly to require the provision of adequate community retardation services, including community-based residential services [61] in every community in the state.[62]

An unbroken line of state court decisions has so construed the Pennsylvania statute and has applied it to require the development and provision of residential and related services in the community (see the blue Brief in Opposition of PARC et al. 20-22). Since that briefing the Pennsylvania Supreme Court has given additional confirmation to the reading of *Hoolick v. Retreat State Hospital* by the lower courts (69a-70a, 125a), and in the Brief in Opposition 22, n. 20. In *Bell v. Thornburgh,* (Nos. 80-2-283 and 296, September 22, 1980), that Court dissolved a lower state court order prohibiting transfers from a State Mental Hospital to alternative facilities and held:

> "Common understanding recognizes that particular facilities are not immune from deterioration and that they therefore will, at some point, outlive their usefulness. When that point is reached, it is reasonable for a patient to expect to receive adequate treatment somewhere—it is unreasonable to expect to receive it at that particular facility." Slip Op. at J-292-16

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60. (Cont'd.)

See 1 Pa. C. S. A. 1921(7); *cf. Hellertown Manufacturing Company v. Pennsylvania,* 480 Pa. 358, 365, 390 A. 2d 732, 735 (Pa. S. Ct. 1978).

61. The 1966 Act defined "aftercare", one of nine services mandated in every county, § 4301(6), 228a, to include "foster home placement, home visiting, . . . halfway houses." See also Pa. Act 256 (1970), 235a-236a.

62. The 1966 Act's requirements of "equitable provision", far from conditioning rights upon funding (Pet. Br. 41), is to "make those services available to every citizen in every community which are now available only to a lucky few, in the more progressive communities." Sen. Pechan, A2.

Petitioners argue (Br. 41) that § 4509(5) of the Act, 229a, suspends their § 4201 and § 4301 duties. As the Court of Appeals held (125a-128a), § 4509(5) in no event relieves *state* officials of their duty. Furthermore, the district court found (43a-44a), that since 1970 and still, $18 million in unspent capital funds have been available to the five county Petitioners here for community facilities for Pennhurst residents. Thus, the statutory condition precedent to any § 4509(5) suspension of the five counties' duties never arose, nor did any county seek § 4509(5) relief (916a).[63]

The state law decision by the courts below supports the judgment in this case in its entirety (151a, 157a-161a, 175a) and should not be disturbed here.

IV. The Remedy Ordered by the District Court Was Well Within Its Equitable Discretion and Was Compelled by the Evidence, by the Position Taken by Defendants and by Section 6010.

The record in this case, including the position taken by defendants, made the district court's choice of remedy inescapable:

> "[O]ur Order must provide that immediate steps be taken to remove the retarded residents from Pennhurst. Great caution and care must be exercised, however, to make certain that each and every retarded resident who is moved from Pennhurst be accommodated in a community facility which will provide minimally adequate habilitation." (77a).

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63. The record shows that in every year from fiscal 1972 through 1975, the five counties returned community services operating funds to the state unspent, some $7 million altogether. PARC Ex. 58, 1020a-22a.

Furthermore, the courts below found, 44a-45, 105a, 160a n. 39, the cost of proper community services per person is less than costs at Pennhurst. Petitioners' unused option of transferring Pennhurst dollars to the community with the residents accounts for the Court of Appeals statement at 127a, mistaken at Pet. Br. 41. See Brief of Amici National Association for Retarded Citizens, et al., pp. 19-23.

Pennhurst, on the trial record of its seventy years and its continuing, current destructive reality, is clearly one of those "custodial" "anachronisms" identified by the Congress as "unsuitable for treatment, education and habilitation programs," "by [its] nature, [its] size, [its] isolation, [its] impersonality," S. Rep. 94-160 at 32-33. It exemplifies the "historic evil of national proportions," *Albemarle Paper Co. v. Moody,* 422 U. S. 405, 416 (1975), against which the Congress directed Section 6010. As to the particular institution Pennhurst, therefore, Section 6010 requires "rapid steps . . . to phase [it] out" and instead "the development of community alternatives." The district court's remedial conclusions by no means arose from the inexorability of any *per se* rule; its examination of remedy was structured precisely as the Congressionally intended presumption would have required and the remedy itself was clearly formed by the imperatives of the factual record before the court.

Furthermore, as the following also shows, even were respondents PARC et al. incorrect in the analysis of Section 6010 presented at Argument I above, on the record of this case the character and direction of the remedy chosen by the district court was correct. Given "the practicalities of the situation," *Davis v. Board of School Commissioners of Mobile County,* 402 U. S. 33, 37 (1971), disclosed by this record, seeking to improve Pennhurst by fixing it up would have been neither feasible nor practicable; such a remedy could not conceivably have "promise[d] realistically to work." *Green v. County School Board of New Kent County,* 391 U. S. 430, 439 (1968); *Milliken v. Bradley,* 433 U. S. 267, 280 n. 15 (1977).

As to remedy, the record before the district court showed:[64]

A. that the responsible state officials had concluded that Pennhurst is "a total loss to the Commonwealth as a mental retardation service facility," that "all of its

64. The citations which follow are illustrative, not exhaustive. The Exhibits cited were each admitted into evidence at Trial Transcript of April, 1977, pp. 1-47 to 1-64.

buildings . . . are totally unsuitable for modern mental retardation purposes" and that it is more cost-effective, as well as more effective for habilitation, to provide family-scale residential facilities and other programs in the community than to renovate or rebuild Pennhurst. See, *e.g.*, 1969-70 Pa. State Plan for Construction of Facilities for the Mentally Retarded, PARC Ex. 21, 946a; April 7, 1972 Letter of Pa. Commissioner of Retardation to Deputy Secretary Secretary, Pa. D. P. W., PARC Ex. 25, 958a-965a; 1972 Capital Renovation and Construction Investment Plan, *id.*, 966a-970a; *1975 Report of Pa. Governor's Management Review Panel* 39, 55, PARC Ex. 28, 975a, 979a; Trial testimony of Hersh, 768a-77a, Walker, 779a, and Thurman, 793a, three retardation experts who in 1977 conducted a three month study of Pennhurst for Pa. D. P. W.

B. that numerous efforts to improve Pennhurst over many decades had failed. For example, the newest institutional building built at Pennhurst at a cost of over $6 million was entirely unsuited to modern habilitation programs. Letter of Pa. Commissioner, *supra,* 958a-960a; Testimony of Pennhurst Superintendent Youngberg, 840a; Dybwad, 542a; Pennhurst Chief Psychologist Hirst, 580a.

On other failed efforts to improve Pennhurst, see, e.g., Pennhurst Assoc. Superintendent Smilovitz, *A History of Pennhurst, 1908-1926, Compiled from Superintendents' Documents* (1974) PARC Ex. 38, 988a-995a; Pa. D. P. W., *Annual Reports,* PARC Ex. 41; Dybwad, 562a-565a; Schmidt, 804a-812a; Brown, 679a-682a.

C. that expenditures at Pennhurst had already reached $60 per resident per day, 44a ($22,000 per resident per year in fiscal year 1976 dollars; $27 million total for fiscal 1976), placing Pennhurst in the highest 5% in per resident expenditures among public retardation institutions in the United States,[65] and that proper community residential and other services can be provided for every Pennhurst resident at less cost. See April

7, 1972 Letter of Pa. Retardation Commissioner, *supra; 1975 Report of Pa. Governor's Management Review Panel, supra;* Regional Commissioner Rice, 891a; Testimony of plaintiff's economist Conley, 710a-723a, and *compare* PARC Ex. 65, 1044a, *with* Montgomery County Community Cost Estimate for 121 Pennhurst Residents, PARC Ex. 33, 938a-984a.

D. that the numbers of direct care staff at Pennhurst met statutory and regulatory standards, and that staff were dedicated and sincere for the most part, but still Pennhurst residents were continually "subjected to abominable conditions" which routinely imposed regression, injury and abuse upon them. That direct care and professional staff shortages were constant at Pennhurst from its beginning and persisted throughout despite major recruiting efforts and higher salaries because Pennhurst is remote from population centers where such retardation professionals are gathered and because of Pennhurst's chronically dreary and unproductive working conditions. Testimony of Clements, 315a, Roos, 286a; Lancaster-Gaye, 417a; Smilovitz, *A Brief History of Pennhurst, supra;* Testimony of Pennhurst Superintendent Youngberg, 833a; Testimony of Dybwad, 549a-551a; Testimony of Conley, 708a-709a.[66]

E. that at the Willowbrook institution in New York City, two years after judgment and after the population of Willowbrook had been reduced by half, the number of staff doubled, and per person annual expenditures increased five-fold, to $26,300 annually and then sevenfold to $35,000 annually,[67] still the Chairman of the

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65. R. C. Scheerenberger, *Public Residential Services for the Mentally Retarded* 36, Table XXXIII (National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, 1976). See also E. Butterfield, "Some Basic Changes in Residential Facilities" in *President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded* 15, 32-33 (2d ed. 1976).

66. Compare, e.g., 1973 S. Hearings at 243.

court-appointed Willowbrook Review Panel testified to this district court: "There was no way we have been able to make Willowbrook a good place to live." Clements, 358a.

F. that every retardation professional who serves for Pennhurst as a "neutral fact finder", whose "independent judgment" the Court held in *Parham v. J. R.*, 442 U. S. 584, 606-07, 614-17 and *Secretary v. Institutionalized Juveniles*, 442 U. S. 640, 647-50 (1979) to be required by due process before a child may be constitutionally institutionalized, testified to the district court in this case that no one at Pennhurst needed to be in the institution, that each would benefit more from proper community services. See Testimony of Pennhurst Superintendent Youngberg, 829a; Pennhurst Social Services Department, U. S. Ex. 5, 1153a; two successive Regional Commissioners of Retardation, Walker, 792a, and Rice, 862a; Pennsylvania D. P. W. Director of Community Living Arrangements Knowlton, 928a, 941a.

G. that three experienced retardation professionals who had studied Pennhurst and its people intensively for three months in 1977 under contract to state defendants (1) found Pennhurst entirely unfunctional for effective retardation services and unable to be altered in any practical way to be functional; (2) and unanimously recommended in a 365 page report to defendants and in testimony to the district court that Pennhurst should be entirely replaced by community living arrangements and each of its residents transferred to such facilities, 768a-777a, 779a, 793a.

H. that after judgment below at the hearings on remedy state defendants themselves affirmatively spoke again what had been throughout trial, and for the decade before, their position on remedy for Pennhurst: that Pennhurst should be entirely replaced with community

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67. Note, Implementing Institutional Reforms," 91 Harv. L. Rev. 428, 434 n. 31 (1977).

living arrangements and every Pennhurst resident transferred to community facilities and programs. (23a, 47a-48a, 77a-78a).

These are among the unchallenged and indisputable facts which framed the remedial inquiry and the conclusion summarized by Judge Broderick in his finding:

> "On the basis of the evidence presented in these proceedings, we find that the retarded residents of Pennhurst have not received, and are not receiving, minimally adequate habilitation. Furthermore, on the basis of this record we find that minimally adequate habilitation cannot be provided in an institution such as Pennhurst. As the Court has heretofore found, Pennhurst does not provide an atmosphere conducive to normalization which is so vital to the retarded if they are to be given the opportunity to acquire, maintain and improve their life skills. Pennhurst provides confinement and isolation, the antithesis of habilitation. We found that Pennhurst has produced regression and in many instances has destroyed life skills possessed by its retarded residents at the time of their admission." (58a)

Even if every other record consideration which contributed to the district court's determination that the remedy it entered was the only practicable and effective remedy available to it were to be disregarded, the consistent expressions of defendants that *their* choice of remedy—if there has to be any remedy at all—was to replace Pennhurst with community services may have required the district court to enter the remedy it did. State and county defendants' complaint to this Court is not about the character of the remedy but that any remedy at all was ordered.

The character and direction of the remedy entered by the district court was affirmed by the Court of Appeals. (156a, 160a). The differences between the two courts touch only the question whether the primary focus for judicial inquiry under the statute should be individual determina-

tions or the propriety of a particular long-standing institutional program. For the reasons set forth above at Argument I, respondents PARC et al. believe Section 6010 and considerations of the judicial role require the latter focus. The remedial consequence of this view, should it be adopted by the Court, would be to reinstate the district court's order requiring that immediate steps be taken to remove retarded people from Pennhurst to proper community-based facilities and services and to disallow further admissions to Pennhurst.

CONCLUSION

For the foregoing reasons, Respondents Pennsylvania Association for Retarded Citizens, Jo Suzanne Moskowitz, Robert Hight, David Preusch and Charles DiNolfi, for themselves and the class they represent, respectfully request that the judgment and orders of the district court be approved, the judgment of the Court of Appeals for the Third Circuit be modified in the particulars specified above and affirmed *pro tanto*.

Respectfully submitted,

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APPENDIX A

Compilation of Congressional Hearings and Reports, 1972-1975

On the Developmentally Disabled Assistance and Bill of Rights Act of 1975, see during the 93d Cong., 1st Sess. (1973): *Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973,* Hearings on S. 427 and S. 458 Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare [cited as "1973 S. Hearings"]; during the 93d Cong., 2d Sess. (1974): *Developmentally Disabled Assistance and Bill of Rights Act, 1974,* Hearings on S. 3378 Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare [cited as "1974 S. Hearings"]; *Health Services and Health Revenue Sharing,* Hearings on H. R. 11511, 11518, 11845 and 12892 Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce, Part 2 [cited as "1974 H. R. Hearings"]; S. Rep. 93-1169; H. R. Rep. 93-1127; during the 94th Cong., 1st Sess. (1975): *Developmentally Disabled Assistance and Bill of Rights Act, 1975,* Hearings on S. 462 Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare [cited as "1975 S. Hearings"]; *Health Services Programs,* Hearings on H. R. 2954 Before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce [cited as "1975 H. R. Hearings"]; S. Rep. 94-160, see especially the parts at 26-39, "Forces Behind Institutionalization and Deinstitutionalization" and "Bill of Rights for the Mentally Retarded and Other Individuals with Developmental Disabilities" which accompany Title II, the Bill of Rights; H. R. Rep. 94-58; H. Conf. Rep. 94-473.

On the Education for All Handicapped Children Act of 1975 and its predecessor Elementary and Secondary Education Amendments of 1974, see during the 93d Cong., 1st Sess. (1973): *Education of the Handicapped Act Amendments,* Hearings Before the Select Subcomm. on Education of the House Comm. On Education and Labor; *Education for the Handicapped, 1973,* Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare; during the 93d Cong., 2d Sess. (1974): *Financial Assistance for Improved Educational Services for Handicapped Children,* Hearings Before the Select Subcomm. on Education of the House Comm. on Education and Labor; *Education for All Handicapped Children, 1973-74,* Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare, Parts 1-4; H. R. Rep. 93-805; S. Rep. 93-763; H. Conf. Rep. 93-1211; during the 94th Cong., 1st Sess. (1975): *Education for all Handicapped Children, 1975,* Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare; H. R. Rep. 94-332; S. Rep. 94-168; H. Conf. Rep. 94-664; S. Conf. Rep. 94-455.

On the Rehabilitation Act of 1973 and the succeeding Rehabilitation Amendments of 1974, see during the 92d Cong., 2d Sess. (1972): *Vocational Rehabilitation Services for the Handicapped,* Hearings Before the Select Subcomm. on Education of the House Comm. on Education and Labor; *Rehabilitation Act of 1972,* Parts 1 & 2, Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare; H. R. Rep. 92-928; S. Rep. 92-1135; H. Conf. Rep. 92-1581; during the 93d Cong., 1st Sess. (1973): *Vocational Rehabilitation Services,* Parts 1 & 2, Oversight Hearings Before the Select Subcomm. on Education of the House Comm. on Education and Labor; *Rehabilitation Act, 1973,* Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare; H. R. Rep. 93-244; S. Rep. 93-318; H. Conf. Rep. 93-500; during the 93d Cong., 2d Sess. (1974): *Rehabilitation Act Amendments of 1974,* Hearings Before the Sub-

comm. on the Handicapped of the Senate Comm. on Labor and Public Welfare; H. Rep. 93-1048; S. Rep. 93-1139; H. Conf. Rep. 93-1457.

On the White House Conference on Handicapped Individuals Act, see S. Rep. 92-1080, 92d Cong., 2d Sess. (1972); S. Rep. 93-319, 93d Cong., 1st Sess. (1973); S. Rep. 93-1139, 93d Cong., 2d Sess. 31-40 (1974).

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In the Supreme Court of the United States

OCTOBER TERM, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, ET AL., PETITIONERS
v.
TERRI LEE HALDERMAN, ET AL.

MAYOR OF CITY OF PHILADELPHIA, ET AL., PETITIONERS
v.
TERRI LEE HALDERMAN, ET AL.

PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, ET AL., PETITIONERS
v.
PENNHURST STATE SCHOOL AND HOSPITAL, ET AL.

COMMISSIONERS AND MENTAL HEALTH/MENTAL RETARDATION ADMINISTRATORS FOR BUCKS COUNTY, ET AL., PETITIONERS
v.
TERRI LEE HALDERMAN, ET AL.

PENNHURST PARENTS-STAFF ASSOCIATION, PETITIONER
v.
TERRI LEE HALDERMAN, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES

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OCTOBER TERM, 1980

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v.

TERRI LEE HALDERMAN, ET AL.

No. 79-1408

MAYOR OF CITY OF PHILADELPHIA, ET AL., PETITIONERS

v.

TERRI LEE HALDERMAN, ET AL.

No. 79-1414

PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, ET AL., PETITIONERS

v.

PENNHURST STATE SCHOOL AND HOSPITAL, ET AL.

No. 79-1415

COMMISSIONERS AND MENTAL HEALTH/MENTAL RETARDATION ADMINISTRATORS FOR BUCKS COUNTY, ET AL., PETITIONERS

v.

TERRI LEE HALDERMAN, ET AL.

No. 79-1489

PENNHURST PARENTS-STAFF ASSOCIATION, PETITIONER

v.

TERRI LEE HALDERMAN, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF FOR THE UNITED STATES

QUESTIONS PRESENTED

1. Whether Section 111 of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. 6010, secures to mentally retarded persons the right to appropriate treatment rather than subjection to the conditions demonstrated by this record.

2. Whether such persons have a private remedy to enforce the rights secured by that Section.

3. Whether the relief awarded by the court below was inappropriate.

4. Whether Pennsylvania law provides mentally retarded persons a right to adequate treatment.

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OPINIONS BELOW

The opinion of the court of appeals (J.A. 92a-196a)[1] is reported at 612 F. 2d 84; the opinion of the district court (J.A. 6a-75a) is reported at 446 F. Supp. 1295.

JURISDICTION

The judgment of the court of appeals was entered on December 13, 1979. The petitions in Nos. 79-1404 and 79-1414 were filed on March 12, 1980, and the petitions in Nos. 79-1408 and 79-1415 were filed on March 12, 1980. Mr. Justice Brennan extended the time for filing a petition in No. 79-1489 until April 11, 1980, and that petition was filed on March 20, 1980. All petitions were granted on June 9, 1980. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

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[1] "J.A." refers to the separately bound Joint Appendix in No. 79-1404. "Tr." refers to the trial transcript; "Rice Dep." refers to the deposition of Russel A. Rice, Commissioner of Mental Retardation for Southeastern Pennsylvania, admitted into evidence at Tr. 1-76, 1-77. The cited materials have been designated for inclusion in the Appendix required by the Court's order of October 6, 1980.

In addition, we are lodging with the Court 10 copies of U.S. Ex. 48, which consists of 108 photographs showing the Pennhurst environment (photos 1-56, 96-108), some Pennhurst residents (photos 61-68), and various community living arrangements (photos 59-60, 84-88, 90-92) and community programs for retarded persons in Pennsylvania (photos 57-58, 89, 93-95). The photographs are discussed in testimony by expert witnesses at Tr. 2-37 to 2-67 (photos 1-44); 1-168 to 1-172 (photos 45-56); 6-176 to 6-178 (photos 59 and 60); 6-141 to 6-152 (photos 64, 68, 102, 103); 6-52 to 6-64 (photos 69 through 83); 5-146 to 5-164 (photos 89 through 95).

STATEMENT

A. Procedural History

This case was brought in the United States District Court for the Eastern District of Pennsylvania, to obtain relief from the restrictions imposed upon plaintiffs by conditions in Pennhurst, an institution for the mentally retarded operated by the Commonwealth of Pennsylvania. The plaintiff class includes the approximately 1,230 persons who resided in Pennhurst at the time of trial (J.A. 9a-10a, 19a) and all persons who may in the future be placed in Pennhurst (J.A. 14a). The Pennsylvania Association for Retarded Citizens, several additional individual mentally retarded persons, and the United States intervened as plaintiffs.[2] After a lengthy trial, the district court found that plaintiffs' confinement at Pennhurst and subjection to its conditions violated the Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794) and a Pennsylvania statute (Pa. Stat. Ann. tit. 50, § 4201 *et seq.* (Purdon 1969)). The district court ordered defendants to phase out Pennhurst, and place its residents in less restrictive community living arrangements established pursuant to Pennsylvania law.[3]

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[2] Following trial, and after notice of appeal had been filed, petitioners in No. 79-1489 sought to intervene in the district court and intervention was denied. The denial was affirmed by the court of appeals (79-1489 Pet. App. 213a), but that court subsequently allowed intervention for the purpose of seeking certiorari, and these petitioners were allowed to intervene in the district court to participate in the proceedings to determine the relief to be awarded (Pet. 5 n.10).

[3] The district court found that "[m]any individuals now living at Pennhurst could be moved immediately into the

While this was being done, conditions at Pennhurst were to be improved. The court appointed a special master to oversee the implementation of its order, including the individual placement decisions.[4]

On appeal, the en banc court of appeals held that defendants were violating both Pennsylvania law and Section 111 of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. 6010. Applying the standards of *Cort* v. *Ash*, 422 U.S. 66, 78 (1975), the court also concluded that the statute authorized plaintiffs' suit (J.A. 114a-122a). The court of appeals did not reach defendants' challenge to the district court's holding that they had violated the Constitution and Section 504 of the Rehabilitation Act of 1973 (J.A. 131a, 141a).[5]

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community and would be able to cope with little or no supervision. * * * All the parties in this litigation are in agreement that given appropriate community facilities, all the residents at Pennhurst, even the most profoundly retarded with multiple handicaps, should be living in the community" (J.A. 43a).

In its memorandum accompanying its relief order, the district court noted that "the Commonwealth defendants agreed that the retarded should be removed from Pennhurst and readily admitted that the only reason that the litigation was necessary was because they wished to accomplish the closing of Pennhurst as a residence for the retarded, pursuant to their own schedule which was vague and indefinite" (J.A. 78a).

[4] The district court first attempted, without success, to obtain from the defendants proposals for implementing appropriate relief (J.A. 77a-79a).

[5] No question relating to these claims is presented by the petitions. Since we believe the court of appeals' holding was correct, we do not discuss the district court's holdings on these claims as alternative grounds for affirmance. See *Cole*

The court of appeals substantially affirmed the district court's order. It reversed that part of the order requiring the closing of Pennhurst, and instead directed the district court, with the assistance of the special master, to consider the possibility, when making the individual placement decisions required by the district court's order, that in an extreme situation remaining at an "improved Pennhurst" might be the appropriate placement (J.A. 156a).[6]

Three judges dissented (J.A. 162a). They would have found that conditions at Pennhurst violated plaintiffs' constitutional and statutory rights, but would not have required changing any class member's placement.

B. Facts

The district court found, and the court of appeals affirmed, "that Pennhurst as an institution is inappropriate and inadequate for the habilitation of the retarded," and that it was admitted by the defendants that "Pennhurst does not meet minimally acceptable professional standards" (J.A. 23a, 47a).[7]

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v. *Ralph*, 252 U.S. 286, 289-290 (1920); cf. *Mazer* v. *Stein*, 347 U.S. 201, 208 n.6 (1954); *General Talking Pictures* v. *Western Electric*, 304 U.S. 175, 177-179 (1938). Should the Court agree with petitioners' contentions on the issues presented, the case should be remanded to the court of appeals to consider the district court holdings concerning the Constitution and Section 504. *FTC* v. *Travelers Health Ass'n*, 362 U.S. 293, 298-299 n.4 (1960); *United States* v. *Fleischman*, 339 U.S. 349, 365 (1950); *Owens* v. *Union Pacific Ry.*, 319 U.S. 715, 724 (1943).

[6] The presumption for every individual was to be that community placement was preferable to continued institutionalization.

[7] " 'Habilitation' is the term of art used to refer to that education, training and care required by retarded individuals

1. *Conditions at Pennhurst*

The Commonwealth of Pennsylvania owns and operates Pennhurst for the purpose of providing care, education and training to each of its 1230 residents. The facility, founded in 1908, is located near Spring City, Pennsylvania, a small rural town approximately 30 miles from Philadelphia (J.A. 18a-19a).

Pennhurst is a self-contained unit, and its residents do not participate to the degree each is able in normal community life outside of the institution (J.A. 19a, 21a, 43a). About half of the residents of Pennhurst were committed there by court order and half were placed there by a parent or other guardian (J.A. 20a). Those who are over eighteen and who indicate a desire to leave are kept there by court order if the Pennhurst staff ascertains that they are not "ready to go into the community" or if there is no available placement for them in the community (J.A. 40a). Twenty-six percent of the residents are mildly or moderately retarded and 74% are severely or profoundly retarded (J.A. 20a).[8] They are not mentally or emotionally ill, and are not a danger to society

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to reach their maximum development" (J.A. 10a). Unlike mentally ill persons, mentally retarded persons cannot be cured, because mental retardation "is an impairment in learning capacity and adaptive behavior" (J.A. 10a, 49a-50a). However, mentally retarded persons can learn and develop with habilitation—training programs given in settings that enable them to achieve the level of independence and self-care that their abilities permit (J.A. 10a, 41a-42a).

[8] Mental retardation is measured both by intelligence quotient (I.Q.) and by ability to cope with the environment. In general, the I.Q. of a profoundly retarded person is less than 20, of a severely retarded person between 20 and 35, of a moderately retarded person between 36 and 51, and of a mildly retarded person between 52 and 69 (J.A. 10a).

(J.A. 47a). The average Pennhurst resident has spent 21 years there and is 36 years old.[9]

While at Pennhurst, the residents regress, both intellectually and behaviorally; instead of learning self-care skills, they lose them.[10] Maladaptive behavior[11] and regression result from over-crowded wards, lack of privacy, lack of training programs, and an oppressive environment (J.A. 21a, 22a-27a, 34a-36a). The district court also found all those conditions to be typical at Pennhurst.[12] See lodging, photos 1-10, 15-17, 19, 21, 23, 24, 26-33, 40-44, 50, 52-56, 97-108.

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[9] Forty-three percent of the residents had no contact with their families within three years of the trial (J.A. 20a).

[10] Terri Lee Halderman lost her ability to speak (J.A. 36a). Linda Taub, who is blind in addition to being retarded, spent her time sitting and rocking; she was strapped to a wheel chair, though she is able to walk, so the staff "would know exactly where Linda was." Nancy Beth Bowman developed maladaptive behavior—biting and pushing (J.A. 36a-40a).

[11] Maladaptive behavior includes rhythmic motions such as rocking, as well as self injury or severe aggression. This behavior is associated with lack of stimulation and boredom (Tr. 1-96 to 1-98, 5-112). Moreover, exclusive association with others who engage in deviant behavior encourages maladaptive behavior (Tr. 1-151, 2-59, 5-91 to 5-92, 5-113).

[12] There is often excrement and urine on ward floors. Infectious diseases are common (J.A. 34a). Obnoxious odors and excessive noise are prevalent. The noise level is frequently so high that many residents stop speaking. Meals are eaten in large groups without adequate staff supervision where residents may steal food from each other, so some do not get enough to eat (J.A. 35a). Lodging photos 34, 36, 37.

The district court also found that the residents at Pennhurst are harmed physically (J.A. 34a-36a).[13] Many physical injuries are the product of staff neglect and abuse.[14] In addition, the void left by the lack of proper habilitation is filled by extreme use of physical and chemical restraints, and seclusion (J.A. 23a-33a).[15] Physical restraints and seclusion not only have caused physical injuries, but they also prevent residents from learning and using self-care skills (J.A. 31a-32a, 39a-40a).[16]

The "extraordinarily high" (J.A. 32a) administration of drugs at Pennhurst is also harmful. It not only causes hazardous side effects, *e.g.*, hypersensitivity to sunlight, inability to maintain balance and gait, inflammation, bleeding and growth of gum tis-

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[13] Plaintiff Terri Lee Halderman, a resident for eleven years, suffered lost teeth, fractured fingers and toes, and numerous lacerations (J.A. 36a). Plaintiffs DiNolfi (a resident for 34 years), Robert and Theresa Sobetsky (residents since 1971), Hight (a resident for two and one-half weeks), Sorotos (a resident for seven years), Larry and Kenny Taylor (residents for 14 years), Bowman and Taub all received physical injuries, including one resulting in loss of an eye, bruises, bites, scratches, welts, and injuries causing lost teeth (J.A. 36a-40a).

During the single month of January 1977 there were 25 major and 833 minor injuries reported (J.A. 35a).

[14] Staff neglect has even resulted in deaths (J.A. 35a-36a).

[15] One resident was physically restrained for 651 hours in June 1976, 720 hours in August 1976, 674 hours in September 1976, and 647 hours in October 1976 (J.A. 31a).

[16] The seclusion rooms at Pennhurst have hard surfaces, exposed radiators and other dangerous features (J.A. 30a n.34; see lodging photos 97, 98, 100, 101). Seclusion is often used as a substitute for staff attention (J.A. 30a).

sue; it also impedes the habilitation of Pennhurst residents when used as a control device (J.A. 33a).[17]

In sum, the district court found that Pennhurst provides "confinement and isolation, the antithesis of habilitation" (J.A. 58a). Its atmosphere is not conducive to the "normalization which is so vital to the retarded if they are to be given the opportunity to acquire, maintain and improve their life skills" (*ibid.*).[18]

2. *Pennsylvania's Program for Mental Retardation*

Pennsylvania's objective in maintaining a mental retardation program is to provide services that will help mentally retarded persons learn and develop (J.A. 41a, 47a-48a). The Pennsylvania Department of Welfare, which operates Pennhurst (J.A. 19a, 47a-48a), has overall responsibility for assuring "the availability and equitable provision of adequate * * * mental retardation services for all persons who need them." Pa. Stat. Ann. tit. 50, § 4201(1) (Purdon 1969). County officials in Pennsylvania are responsible for identifying mentally retarded persons in need of services. Through their "base service units," they determine the setting in which individuals will receive these services (J.A. 45a; see Pa. Stat. Ann. tit. 50, § 4302 (Purdon 1969)). Although State policy strongly favors habilitation of retarded individuals within their communities, the defendant county officials have failed substantially to comply

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[17] Larry Taylor was given unneecssary medication that caused him to fall asleep in school (J.A. 38a).

[18] The district court's graphic description (J.A. 18a-46a) of conditions at Pennhurst, summarized above, was accepted by the court of appeals (J.A. 106a) and is not challenged here.

with this policy for Pennhurst residents (J.A. 41a, 43a, 46a).

The Department of Welfare receives funding requests from the counties, reviews them and incorporates them into the appropriation requests for mental health and mental retardation services. The funds are then made available to the counties through the Department of Welfare (Rice Dep. 77-86, 89-92, 95-97, J.A. 106a-107a). Funds available under federal law for mental retardation services are paid to the Department of Welfare, which includes these funds in its spending allocations. For example, the federal funds paid to Pennsylvania under the Developmental Disabilities Act are included in the state budget for mental retardation services, and are distributed by the state to the counties through the Department of Welfare (Rice Dep. 121A-125A, 136A, 138A-140A). Similarly, part of Pennsylvania's "Medicaid" funds (42 U.S.C. 1396d) are used to fund Pennhurst (Rice Dep. 126-127).[19]

3. *Alternative Habilitative Settings in Pennsylvania*

Pennsylvania has adopted a policy of establishing community living arrangements for the care and training of mentally retarded persons (J.A. 41a, 43a).[20] The district court found that policy was

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[19] For fiscal 1975-1976, $5,870,000 in Medicaid funds were paid to Pennhurst (Tr. 26-14). For that year, the counties received $661,705 in Developmental Disabilities Act funds (PARC Ex. 65 at 61).

[20] In community living arrangements, retarded persons live in appropriately structured environments in family-type dwellings in residential neighborhoods. They participate in the life of the community to the extent that they are able to

based on two considerations: First, it gives effect to the principle of "normalization" that Pennsylvania authorities espouse—namely, that the retarded person should be treated as much like the non-retarded person as possible (J.A. 41a-43a).[21] Second, the costs of providing habilitative services in the community are markedly lower than the cost of maintaining persons in Pennhurst (J.A. 44a).

The services required to habilitate mentally retarded persons locally exist in the five counties from which Pennhurst draws its residents. Persons of all levels of retardation reside in various living arrangements in these counties and receive the services they need (J.A. 42a-43a). Moreover, in 1970, the Pennsylvania legislature appropriated $21 million for planning, designing and constructing additional community facilities to enable 900 Pennhurst residents to be transferred to the community. By trial time in 1977, however, only 37 Pennhurst residents had been transferred to new facilities, and more than $18

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do so; for example, they may attend educational programs in local schools and churches, work at suitable jobs, enjoy community recreation facilities, or shop in community stores (Tr. 5-141 to 5-142, 5-160 to 5-161, 6-7 to 6-10, 6-29 to 6-31, 6-170 to 6-172, 6-173 to 6-174, 6-176 to 6-177, 7-69 to 7-70, 8-4 to 8-44, 8-47, 8-51 to 8-52, 10-66 to 10-108, 10-104 to 10-174, 11-38 to 11-52, 11-62 to 11-78, 11-80, 11-81, 11-109).

[21] The district court agreed that this principle was a proper one, crediting evidence that the "smaller the living unit in which the retarded individual lived, the higher the level of behavioral functioning shown by the individual" (J.A. 41a), and that "once removed from depressing, restrictive routines, the retarded have been able to accomplish a great deal" (J.A. 42a).

million of the appropriation remained unspent (J.A. 43a-44a).[22]

SUMMARY OF ARGUMENT

Section 111 of the Developmentally Disabled Assistance and Bill of Rights Act provides that the developmentally disabled "have a right to appropriate treatment services and habilitation * * * which should be provided in the setting that is least restrictive of the person's personal liberty", and that the "Federal Government and the State both have an obligation to assure that public funds are not provided" to any institution that does not provide appropriate care, and does not meet minimum standards for decent living conditions. This clear statement of individual rights is the result of a legislative compromise between the Senate's desire to impose detailed federal standards requiring the least restrictive appropriate treatment and the House of Representatives' preference for financial incentives to encourage the states to adopt de-institutionalization programs. Although the compromise eliminates the detailed statutory treatment standards proposed by the Senate, it retains the Senate's emphasis on the individual's right to appropriate treatment as well as to humane living conditions, and expresses a strong preference for de-institutionalization.

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[22] Pennsylvania officials plan to spend $1,028,327 at Pennhurst to correct Safety Code violations, and $2,367,500 to meet medical care standards. With these expenditures, and by reducing the Pennhurst population to 850, they expect to certify all Pennhurst wards for Medicaid payments (J.A. 19a n.14).

The right to appropriate treatment is judicially enforceable by institutionalized individuals. The claim that public officials acting under color of state law have deprived plaintiffs of their civil rights guaranteed by Section 6010 is cognizable under 42 U.S.C. 1983 and also directly under 42 U.S.C. 6010. The language of Section 6010, as well as its legislative history and the structure of the Developmental Disabilities Assistance and Bill of Rights Act, shows that Congress intended to give institutionalized individuals a cause of action, in addition to the express remedy of a fund cutoff by the Secretary of Health and Human Services.

In light of the pervasive violations of the rights guaranteed by Section 6010 shown by this record, the remedy approved by the court of appeals was fully justified. That remedy implements the statutory preference for de-institutionalization by requiring a presumption in favor of reassignment to community living arrangements, while permitting continued confinement at an improved Pennhurst if that is found to be the most appropriate placement.

The obligation in this case to provide adequate services to the mentally retarded in an environment as similar to normal as possible is based on state, as well as federal, law.

ARGUMENT

I. THE "BILL OF RIGHTS" SECTION OF THE DEVELOPMENTALLY DISABLED ASSISTANCE AND BILL OF RIGHTS ACT SECURES THE RIGHT TO APPROPRIATE TREATMENT

The court of appeals properly held that inappropriate placement at Pennhurst violated Section 111 of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. 6010 (J.A. 200a).[23]

Section 6010 is a clear statement that developmentally disabled persons (including those who are mentally retarded),[24] who have been placed in in-

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[23] This Act, Pub. L. No. 94-103, 89 Stat. 486, amended and renamed the Developmental Disabilities Services and Facilities Construction Act, Pub. L. No. 88-164, 77 Stat. 282. The amended Act provides funds for construction and for special projects to service developmentally disabled persons, and provides allotments to assist states in their programs for developmentally disabled persons. 42 U.S.C. 6062, 6063. Section 6010 is part of Title II of the Act, called the "Bill of Rights." Titles I and III of the Act contain the funding arrangements. The plans required as a condition of receiving a state allotment under Title III (42 U.S.C. 6061-6068) cover all aspects of the states' service delivery systems for the developmentally disabled. See, *e.g.*, 42 U.S.C. (Supp. II) 6063 (b) (1) and 6063(b) (2) (B); see also H.R. Rep. No. 94-58, 94th Cong., 1st Sess. 4-5 (1975); H.R. Rep. No. 95-1188, 95th Cong., 2d Sess. 4-5 (1978).

[24] A developmental disability is "a severe, chronic disability of a person which—(A) is attributable to a mental or physical impairment or combination of mental and physical impairments; (B) is manifested before the person attains age twenty-two; (C) is likely to continue indefinitely; (D) results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic self-sufficiency; and (E) reflects

stitutions at federal and state expense, have certain rights.[25] Where there is such federal and state sup-

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the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated." 42 U.S.C. (Supp. II) 6001(7); cf. 42 U.S.C. 6001(7).

[25] 42 U.S.C. 6010 provides in pertinent part:

> Congress makes the following findings respecting the rights of persons with developmental disabilities:
>
> (1) Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities.
>
> (2) The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.
>
> (3) The Federal Government and the States both have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that—
>
> (A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons; or
>
> (B) does not meet the following minimum standards:
>
> (i) Provision of a nourishing, well-balanced daily diet * * *
>
> (ii) Provision * * * of appropriate and sufficient medical and dental services.
>
> (iii) Prohibition of the use of physical restraint * * * unless absolutely necessary and prohibition of the use of such restraint

port, as there is at Pennhurst, this succinct statement of rights imposes on the state and federal governments an obligation to ensure that institutionalized persons [26] are free from harmful conditions such as those found at Pennhurst—*i.e.*, from treatment that is not "appropriate", and from conditions that do not meet minimum living standards.[27]

> as a punishment or as a substitute for a habilitation program.
>
> (iv) Prohibition on the excessive use of chemical restraints * * * and the use of such restraints as punishment or as a substitute for a habilitation program or in quantities that interfere with services, treatment, or habilitation * * *.
>
> (v) Permission for close relatives * * * to visit * * * at reasonable hours * * *.
>
> (vi) Compliance with adequate fire and safety standards as may be promulgated by the Secretary.
>
> (4) All programs for persons with developmental disabilities should meet standards which are designed to assure the most favorable possible outcome for those served * * *.

[26] The question whether 42 U.S.C. 6010 rights extend to developmentally disabled persons who are in a non-residential state sponsored program is not presented here (Pet. Br. 10). However, the "obligation" extends explicitly to "any institutional or other residential program." 42 U.S.C. 6010(3).

[27] Although petitioners suggest (Br. 10) that more than two million persons are covered by the Act, the district court noted (J.A. 13a-14a n.7) that nationwide in 1976 there were 154,000 mentally retarded persons in public institutions, 32,000 in hospitals for the mentally ill and 32,000 in private institutions of various kinds. Petitioners offer no reason to suggest that these numbers have substantially increased since 1976, and we are aware of none.

While phrased as "findings," 42 U.S.C. 6010 is more than simply an expression of hope or a guide for the use of federal funds. The statement of "a right" in subsection 6010(1) is supplemented by subsection 6010(3), which plainly places the corresponding duty on the Federal Government and the States. The mandatory language of these two subsections contrasts with the use of the word "should" in subsections 6010(2) and 6010(4).[28] Congress could scarcely have stated more clearly its intent to assure that developmentally disabled persons have the right to appropriate treatment, as well as to humane living conditions.[29] That intent was further emphasized by the 1978 amendment to the section,[30] which states

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[28] Subsection 6010(2), which provides that treatment and habilitation "should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty", aids in determining whether a particular habilitation program is "appropriate" and makes clear that Congress approved the "least restrictive alternative" concept, although the statute also contemplates appropriate institutional care for some developmentally disabled persons.

[29] Petitioners agree (Br. 11 n.18) that "a State must run its institutions for the retarded in a decent and humane fashion", but they incorrectly conclude that is the limit of the duty. The statute does not say that *either* appropriate treatment *or* humane living conditions is required. If it did, it would authorize incarceration of a mentally retarded person regardless of that person's developmental potential or ability for self-care as long as living conditions were humane, a clear violation of *O'Connor* v. *Donaldson*, 422 U.S. 563, 575 (1975). In light of the legislative history discussed *infra*, pages 18-20, Congress could hardly have limited the statutory guarantee to humane living conditions.

[30] Congressional intent may be clarified by the treatment of a statute in later amendments. *Red Lion Broadcasting Co.* v. *FCC*, 395 U.S. 367 (1969).

that "[t]he rights * * * described" in Section 6010 are "in addition to any constitutional or other rights" afforded to all persons (42 U.S.C. (Supp. II) 6010).[31]

The statutory language thus indicates that Section 6010 rights, like the "constitutional or other rights" to which they are analogized, are intended to be legally enforceable. Moreover, the legislative history demonstrates that Congress intended the statute to have the legal effect of securing and protecting the rights of mentally retarded persons in the care of the state. Section 6010 was enacted through a compromise between the Senate and the House of Representatives. In 1975, both houses of Congress passed bills aimed at (1) improving the conditions under which the nation's mentally retarded and other developmentally disabled persons are cared for, and (2) moving persons out of institutions and into community based programs. The House bill, H.R. 4005, 94th Cong., 1st Sess. (1975), relied on achieving these objectives through financial incentives. See 121 Cong. Rec. 9976-9982 (1975); H.R. Rep. No. 94-58, 94th Cong., 1st Sess. (1975). The Senate bill, S. 462, 94th

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[31] The 1978 amendments also require the state plans to provide protection, "consistent with section 6010" of "the human rights of all persons * * * receiving treatment, services, or habilitation under programs assisted under this chapter" (42 U.S.C. (Supp. II) 6063(b)(5)(C)). The statutory framework of the Developmental Disabilities Act, requiring the Secretary to approve a state plan as a condition of the state receipt of federal funds, is analogous to the state plan requirements of the Social Security Act, 42 U.S.C. 602. This Court recognized in *Maine* v. *Thiboutot*, No. 79-838 (June 25, 1980), that the Social Security Act requirements for state plans are judicially enforceable. It follows that the requirements in the similar Developmental Disabilities Act state plans are also judicially enforceable. See also *King* v. *Smith*, 392 U.S. 309, 316-317 (1968).

Cong., 1st Sess. (1975), would also have employed financial incentives, but it contained in addition a Title II, called the "Bill of Rights," intended to provide measures for protection of the rights of mentally retarded persons who are in the federally subsidized care of the states. See 121 Cong. Rec. 16470-16523 (1975); S. Rep. No. 94-160, 94th Cong., 1st Sess. (1975).

A. The Senate bill

The Senate's "Bill of Rights" title would have required states to comply with detailed federal statutory standards in providing both institutional and community based services for developmentally disabled persons, S. 462, *supra*; S. Rep. No. 94-160, *supra*, at 45-76.[32] The Senate thought that adoption of these standards for programs and living conditions in institutions was necessary to protect the human rights of persons confined to institutions. S. Rep. No. 94-160, *supra*, at 34.

Much of the record before the Senate reflected its concern about conditions in state institutions for the mentally retarded revealed in various federal civil suits seeking to protect the constitutional rights of persons confined in those institutions. See, *e.g.*, S. Rep. No. 94-160, *supra*, at 30-31. The Senate committee report points out that the court in *Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), aff'd *sub nom. Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974), defined "minimum constitutional standards for adequate treatment," including the "[r]ight to

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[32] The bill would have prescribed, *inter alia*, evaluation and performance criteria, *id.* at 49; administrative policies, *id.* at 54-56, staff activities and living unit "atmosphere," *id.* at 56-58; standards for professional services, *id.* at 58-59; safety and sanitation standards (*e.g.* prohibition of lead based paint), *id.* at 60; types of recreation and leisure activities, *id.* at 67; and the form and content of records, *id.* at 73.

the least restrictive condition necessary to achieve the purpose of confinement." S. Rep. No. 94-160, *supra*, at 31. Far from expressing any disagreement with these minimum standards, the committee report emphasizes that "[e]very effort should be made to insure that our developmentally disabled citizens are provided every opportunity of being cared for in the least restrictive setting that is consistent with the person's ability for self-care". S. Rep. No. 94-160, *supra*, at 33.[33]

Of particular concern to the proponents of the Senate bill was the federal financial support to institutions where mentally retarded persons were being harmed instead of helped. Senator Javits, the author of the Senate's Bill of Rights (S. Rep. No. 94-160, *supra*, at 29), admonished the Senate, 121 Cong. Rec. 16519 (1975):

> Progress toward recognition of the basic human and civil rights of the mentally retarded and other developmentally disabled persons has been slow. The Federal Government has largely abrogated its responsibility in this regard and recently the greatest initiatives have come from our courts.
>
> Congress should reaffirm its belief in equal rights for all citizens—including the developmentally disabled. Congress should provide the leadership to change the tragic warehousing of

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[33] This reference shows that the Senate endorsed the "least restrictive alternative" standard; it is not necessary for this Court to decide here whether that standard is in fact constitutionally based. Cf. *O'Connor* v. *Donaldson*, 422 U.S. 563, 575 (1975); *Shelton* v. *Tucker*, 364 U.S. 479, 488-490 (1960); *Humphrey* v. *Cady*, 405 U.S. 504 (1972); *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972); *Vitek* v. *Jones*, No. 78-1155 (March 25, 1980); *Parham* v. *J.R.*, 442 U.S. 584 (1979); *Addington* v. *Texas*, 441 U.S. 418 (1979).

> human beings that has been the product of insensitive Federal support of facilities providing inhumane care and treatment of the mentally retarded.

As one means of providing this leadership, the Senate proposed to terminate all federal funds going to any institution if it did not comply with the Senate's detailed and extensive program standards within five years. S. 462, *supra*, at § 206; S. Rep. No. 94-160, *supra*, at 35.[34]

The salient circumstances, therefore, that prompted the Senate's "Bill of Rights" were: (1) the Senate found that confinement of mentally retarded persons in many of the nation's institutions was not beneficial and was often harmful to those persons, (2) the federal courts had held that persons placed in these institutions had a right to appropriate treatment,[35] and (3) federal and state governments were supporting these institutions.

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[34] Foremost among the federal funds which support these facilities are funds under Title XIX of the Social Security Act, 42 U.S.C. 1396d(c) and (d) ("Medicaid"). Petitioners amply demonstrate that "Medicaid" funds going to Pennhurst alone dramatically exceed the funds under the Developmentally Disabled Act going to Pennsylvania's statewide program for mentally retarded persons (Br. 13 n.22, 26 n.43).

[35] *Wyatt* v. *Stickney, supra; Welsch* v. *Likins*, 373 F. Supp. 487, 499 (D. Minn. 1974), aff'd and vaacted in part, 550 F.2d 1122 (8th Cir. 1977); *Gary W.* v. *Louisiana*, 437 F. Supp. 1209, 1219 (E.D. La. 1976); *Davis* v. *Watkins*, 384 F. Supp. 1196, 1206 (N.D. Ohio 1974). The Fifth Circuit had affirmed a "right to treatment" holding, *Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974), and had upheld a jury verdict on a "right to treatment" theory in *Donaldson* v. *O'Connor*, 493 F.2d 507, 521 (5th Cir. 1974), vacated and remanded, 422 U.S. 563 (1975). See also *Burnham* v. *Department of Public*

B. The House of Representatives Bill

The House of Representatives also expressed concern over both inappropriate placement of individuals in institutions and retention of individuals in inhumane and non-habilitative institutions. See Pet. Br. 19-20. Its bill to revise the Developmental Disabilities Services and Facilities Construction Act would have required states to "spend a specified percentage of their allotments for programs for deinstitutionalization of persons with developmental disabilities inappropriately placed in institutions." H.R. Rep. No. 94-58, *supra*, at 1-2. States were to plan "for as much deinstitutionalization as is feasible"; it was "anticipated that these requirements will prompt some movement of patients from State institutions back into their communities." The House Committee "hoped that corresponding amounts of State and other funds currently being spent on institutional care will be rebudgeted for community care, an obvious rebudgeting which has not always occurred in conjunction with deinstitutionalization." *Id.* at 10.[36]

Health, 503 F.2d 1319 (5th Cir. 1974), cert. denied, 422 U.S. 1057 (1975). The District of Columbia Circuit had suggested that confinement of a person for treatment without providing treatment might contravene the Due Process Clause. *Rouse* v. *Cameron*, 373 F.2d 451, 455 (D.C. Cir. 1966). Public officials in New York had virtually conceded a right to treatment and had agreed to an extensive remedy for unconstitutional conditions in the Willowbrook institution. *New York State Ass'n for Retarded Children* v. *Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975).

[36] The House Report included a report from the Secretary of Health, Education, and Welfare on the proposed legislation. The Secretary wrote: "[w]hile we are in basic agreement with the thrust of [the Senate's "Bill of Rights"] * * *, we do not believe that the standards set forth in title II are achievable at the present time; nor are they the best means of

C. The Compromise

Both the House and Senate recognized the need to eliminate inappropriate institutional treatment, but they proposed different solutions. The House, though supporting efforts to enhance the legal rights of the retarded, relied principally on the financing of additional community care facilities to accept the persons inappropriately placed in institutions. The Senate, though it would have provided federal funds for services for developmentally disabled persons, focused on the need to halt infringements of rights resulting from subjection of persons to harmful conditions in institutions supported by federal funds.

These differing approaches were compromised by building on existing HEW standards for mental retardation institutions. 42 U.S.C. 6010(4)(A) (H.R. Conf. Rep. No. 94-473, 94th Cong., 1st Sess. 43 (1975); 121 Cong. Rec. 29820 (1975)).[37] The Secretary of Health, Education, and Welfare was directed to review and evaluate the quality standards under various statutes for their effectiveness in assuring the rights secured by Section 6010, and to report to Congress recommendations for additional legislation. Pub. L. No. 94-103, Section 204, 89 Stat.

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improving the quality of care provided to persons in these facilities." H.R. Rep. No. 94-58, *supra*, at 21-23.

[37] "The conference committe recognizes that the six minimum standards [of 42 U.S.C. 6010(3)(B)] * * * will not in themselves ensure quality habilitation and adequate treatment programs. The committee therefore does not intend these standards to preempt or supplant any existing Federal or State standards currently in force (e.g., standards applicable to Intermediate Care Facilities for the Mentally Retarded under Medicaid), which may require more detailed or higher standards of care."

504.[38] The compromise also expressed a preference for treatment "designed to maximize developmental potential" in the "setting least restrictive of personal liberties" (42 U.S.C. 6010(2)), thus recognizing the principle cited by both houses in their reports that mentally retarded persons benefit from treatment that is in a setting as much like normal life as is possible. Cf. J.A. 41a-42a, 62a.[39] It was explicitly required, however, that treatment, services and habilitation be "appropriate." This requirement reflected the Senate understanding of the legal rights of institutionalized persons. The conference reported: "The conference substitute contains a compromise which specifies rights of the developmentally disabled" (121 Cong. Rec. 29819 (1975)).

Nothing in the legislative history suggests that the House demanded, or that the Senate acceded to,

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[38] Consistent with its reluctance to adopt detailed uniform standards for all federally assisted programs, the House, when it received the recommendations, took no steps to enact them into law. See *Developmental Disabilities Act Amendments of 1978: Hearings on H.R. 11764, 2151 and 10059 Before the Subcomm. on Health and Environment of the House Comm. on Interstate and Foreign Commerce*, 95th Cong., 2d Sess. 471-478 (1978); H.R. Rep. No. 95-1188, 95th Cong., 2d Sess. (1978). It did agree to amend Section 6063 (describing the requirements for state plans) to require the state plans to provide protections for Section 6010 rights. 42 U.S.C. (Supp. II) 6063(b)(5)(C). See note 31, *supra*.

[39] The preference may have a more fundamental legal basis. Mr. Chief Justice Burger, in his concurring opinion in *O'Connor* v. *Donaldson*, *supra*, 422 U.S. at 589, rejected "the theory that a State may lawfully confine an individual thought to need treatment and justify that deprivation of liberty solely by providing some treatment. Our concepts of due process would not tolerate such a 'trade-off'." See also cases cited in note 33, *supra*.

abandonment of measures to secure the legal rights of institutionalized persons for which the Senate found so compelling a need.[40] On the contrary, the conference report states (121 Cong. Rec. 29819 (1975)):

> These rights are generally included in the conference substitute in recognition by the conferees that the developmentally disabled, particularly those who have the misfortune to require institutionalization, have a right to receive appropriate treatment for the conditions for which they are institutionalized, and that this right should be protected and assured by the Congress and the courts.

II. PLAINTIFFS MAY MAINTAIN THIS ACTION TO VINDICATE THEIR SECTION 6010 RIGHTS

Both 42 U.S.C. 1983 and Congress' intent in enacting Section 6010 support plaintiffs' right to maintain an action to remedy their subjection to treatment, services and habilitation that is not "appropriate to [their] needs" in an institution that "does not meet * * * minimum standards."

A. Section 1983 authorizes the action

The complaint in this case relied on Section 1983 as a basis for maintaining the actions (Plaintiffs' Second Amended Complaint at 3). That Section provides in pertinent part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any

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[40] Senator Javits, a principal sponsor of the "Bill of Rights," in lauding its passage said, 121 Cong. Rec. 29820 (1975); "I am particularly pleased that the conferees have included as title II essentially the 'Bill of Rights for the Mentally Retarded' which I originally introduced on June 28, 1972, in response to the tragic situation of institutionalized mentally retarded patients across the Nation."

> State * * * subjects * * * any * * * person * * * to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

The defendants are state and local government officials who operate Pennsylvania's system of care for the mentally retarded "under color of" state statutes, regulations, customs and usages. See *Monroe* v. *Pape*, 365 U.S. 167 (1961); *Monell* v. *New York City Dep't of Social Services*, 436 U.S. 658 (1978). Plaintiffs' claim that they have been deprived of rights guaranteed by Section 6010 thus is cognizable under Section 1983 if those rights are "secured by the Constitution and laws" of the United States.[41]

This Court has recently emphasized that Section 1983 provides a remedy "broadly encompass[ing] violations of federal statutory as well as constitutional law." *Maine* v. *Thiboutot*, No. 79-838 (June 25, 1980), slip op. 3. But even before that decision, it was recognized that Section 1983 provided a remedy for civil rights and equal protection laws (slip op. 5; slip op. 1, 6, 11 (dissenting opinion)). Since Section 6010 is designed to secure civil rights and equal protection, it is not the kind of law that divided the Court in *Thiboutot*.[42]

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[41] "Secured" as used in Section 1983 means "created" or "protected." *Hague* v. *CIO*, 307 U.S. 496, 526-527 (1939).

[42] Petitioners (Br. 29) rely on a footnote in the dissent in *Thiboutot*, indicating that Section 1983 is inapplicable "where the governing statute provides an exclusive remedy for violations of its terms" (slip op. 12, n.11 (dissenting opinion)). As we demonstrate *infra*, pages 28-32, the Developmental Disabilities Act is not such a statute. See *Chapman* v. *Houston Welfare Rights Organization*, 441 U.S. 600, 672 (1979) (White, J., concurring).

B. Section 6010 itself authorizes a private remedy

In *Cort* v. *Ash*, 422 U.S. 66, 78 (1975), this Court identified four factors to determine Congress' intent with respect to allowing a private right of action in a federal statute that does not expressly provide such a remedy:

> First, is the plaintiff "one of the class for whose *especial* benefit the statute was enacted" * * *—that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? * * * Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? * * * And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

Applying these factors to the "Bill of Rights" provisions of the Developmentally Disabled Assistance and Bill of Rights Act, the court of appeals concluded that the provisions created an implied private cause of action (J.A. 115a-121a).[43] The correctness

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[43] One other court of appeals has held that Section 6010 creates an implied private right of action. *Naughton* v. *Bevilacqua*, 458 F. Supp. 610 (D.R.I. 1978), aff'd on other grounds, 605 F.2d 586 (1st Cir. 1979). *Michigan Ass'n for Retarded Citizens* v. *Smith*, 475 F. Supp. 990, 992 (E.D. Mich. 1979), held that the district court had jurisdiction under, *inter alia*, 42 U.S.C. 1983 and 6010, of a suit by residents of a mental retardation institution to remedy conditions in that institution. *Kentucky Ass'n for Retarded Citizens* v. *Conn*, No. C-78-0157L(A) (W.D. Ky. March 21, 1980), did not explicitly address the question of a private right of action under 6010, but considered the merits of a private claim under that Section.

of this holding is reaffirmed by more recent decisions of this Court, which emphasize that implication of a private cause of action is a question solely of statutory construction. *Touche Ross & Co.* v. *Redington*, 442 U.S. 560, 568 (1979); *Cannon* v. *University of Chicago*, 441 U.S. 677, 688 (1979). In resolving that question, the Court held, it is necessary to determine "whether Congress intended to create the private right of action asserted." *Touche Ross & Co.* v. *Redington, supra*, 442 U.S. at 568. See also *Transamerica Mortgage Advisors, Inc.* v. *Lewis*, 444 U.S. 11 (1979).[44]

The language, structure, and circumstances of enactment of Section 6010 strongly suggest congressional intent to provide a private cause of action (cf. *Transamerica Mortgage Advisors, Inc.* v. *Lewis, supra*, 444 U.S. at 18). The statutory language asserts that the developmentally disabled have "a right to appropriate treatment, services and habilitation," and the "Federal Government and the States both have an obligation" to assure that public funds are not provided to institutions that do not provide such treatment (42 U.S.C. 6010(1) and 6010(3)). Moreover, the personal rights described "are in addition to any constitutional or other rights otherwise afforded."

The strong implication of this language that the described rights are to be judicially enforceable by

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[44] The other factors identified in *Cort* v. *Ash, supra*, 422 U.S. at 78, also support a private remedy. The statute was enacted for the *especial* benefit of the developmentally disabled, and although the treatment of the mentally retarded is traditionally a concern of the States, it is entirely appropriate to infer a cause of action based solely on federal law to assure that federal funds do not support inappropriate state programs.

the individuals affected is substantiated by the legislative history. As noted, *supra*, pages 19-20, the Senate Committee focused on the role of the federal courts in remedying institutional conditions—frequently as the result of suits by residents of the institutions themselves. The clear implication was that the statute under consideration was to assist in that process, by providing a further source of authority for correction of conditions that the Senate viewed as intolerable.[45]

While the conference committee refused to adopt the detailed statutory criteria proposed by the Senate, it did agree that the rights that were specified "should be protected and assured by * * * the courts." 121 Cong. Rec. 29819 (1975). This statement must be read in light of the state of the law on judicial remedies in 1975. See *Cannon* v. *University of Chicago*, *supra*, 441 U.S. at 696-698. By that time, four other enactments protecting or creating rights in certain classes—the Voting Rights Act of 1965, Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and Section 504 of the Rehabilitation Act of 1973—had been held to have created implied private causes of action. *E.g.*, *Allen* v. *State Board of Elections*, 393 U.S. 544 (1969); *Bossier Parish School Board* v. *Lemon*, 370 F. 2d 847 (5th Cir.), cert. denied, 388 U.S. 911 (1967); *Gautreaux* v. *Chicago Housing Authority*, 265 F. Supp. 582 (N.D. Ill. 1967); see *Lau* v. *Nichols*, 414 U.S. 563 (1974). Moreover, in 1972 Congress had

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[45] The same Senate Committee which considered the "Bill of Rights" had stated that Section 504 created judicially enforceable private rights. S. Rep. No. 93-1297, 93d Cong., 2d Sess. 38, 40 (1974); see *Camenisch* v. *University of Texas*, 616 F.2d 127, 131 (5th Cir. 1980), and cases there cited.

created a right of action under Title IX through a statement of rights without expressly providing a judicial remedy. *Cannon* v. *University of Chicago*, *supra*. Congress had ample reason to believe that an explicit statement of rights in a statute such as Section 6010 was sufficient to permit enforcement by the benefited class of the rights described there.[46]

The structure of the Act also suggests a congressional intent that there be private judicial remedies. No other adequate remedy was explicitly provided. There was in existing law a procedure for terminating funds allocated under the Act to states that did not comply with the Act, and this was preserved. 42 U.S.C. 6065, 6068.[47] Congress was well aware, however, that fund termination was an inadequate remedy for the important rights Congress sought to protect by enacting Section 6010.[48]

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[46] Petitioners' suggestion that Congress meant to limit court enforcement to suits by the United States (Br. 33 n.52) is not supported by any intent expressed or implied by Congress. Cf. *Cannon* v. *University of Chicago*, *supra*, 441 U.S. at 691-706.

[47] Section 6065 authorizes the Secretary, not private injured parties, to institute fund termination proceedings. The Secretary's regulations authorize intervention in such proceedings by "interested parties" (45 C.F.R. 1386.94(b)(1)).

[48] The Court has cautioned, *Cannon* v. *University of Chicago*, *supra*, 441 U.S. at 711:

> The fact that other provisions of a complex statutory scheme create express remedies has not been accepted as a sufficient reason for refusing to imply an otherwise appropriate remedy under a separate section. * * * Rather, the Court has generally avoided this type of "excursion into extrapolation of legislative intent," * * *

Although the administrative procedure of Section 6065 may help to vindicate the interest of the United States in partially freeing itself from further financing inappropriate institutions—one purpose of the statute—it is of little use in correcting the condition.[49] Termination of the funds provided by the Act would not eliminate the publicly financed wrongs done by institutions such as Pennhurst, because the larger volume of Medicaid funding, as well as state funding, would continue.[50]

Moreover, here, as in the statute under consideration in *Cannon* v. *University of Chicago*, *supra*, 441 U.S. at 704-706 (footnotes omitted):

> [Congress] sought to accomplish two related, but nevertheless somewhat different, objectives. First, Congress wanted to avoid the use of federal resources to support discriminatory practices; second, it wanted to provide individual citizens effective protection against those practices. * * *
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> The first purpose is generally served by the statutory procedure for the termination of federal financial support * * * [but] [t]hat remedy * * * often may not provide an appropriate

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unless there is other, more convincing, evidence that Congress meant to exclude the remedy.

[49] The elimination of federal funding of inadequate state institutions (whose inadequacies typically can be traced at least in part to insufficient funding) is scarcely an appropriate way of improving conditions in those institutions.

[50] Indeed, Section 6065 provides only for the termination of the funds available under the Developmentally Disabled Assistance and Bill of Rights Act, while Section 6010(3) states that no "public funds" are to be provided to inadequate institutions. See notes 19 & 33, *supra*.

> means of accomplishing the second purpose if merely an isolated violation has occurred. * * * The award of individual relief to a private litigant who has prosecuted [his] own suit is not only sensible but is also fully consistent with—and in some cases even necessary to—the orderly enforcement of the statute.

Finally, the requirement of 42 U.S.C. 6012 that States establish advocacy systems with the authority to pursue "legal * * * and other appropriate remedies to insure the protection of the rights of * * * persons who are receiving treatment, services, or habilitation within the State" is also inconsistent with an intent that the Secretary's administrative remedies were to be the only means available to protect Section 6010 rights.

III. THE REMEDY FASHIONED BY THE COURT BELOW WAS AN APPROPRIATE EXERCISE OF ITS DISCRETION

In many respects, Pennhurst is a paradigm of the institutions that prompted Congress to enact Section 6010.[51] The unchallenged factual findings of the district court clearly show that incarceration in Pennhurst violates the specific requirements of Section 6010 in two separate respects: The residents neither receive "appropriate treatment, services, and habilitation," nor are they afforded the "minimum standards" of physical care.

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[51] Much of the description of the "totally unacceptable conditions [that] still prevail" in public mental institutions cited by the Senate (S. Rep. No. 94-160, *supra*, at 28-30) applies directly to Pennhurst. See J.A. 18a-46a.

Assessments of residents' habilitation needs are inadequate (J.A. 27a). The amount of programming for residents is substantially less than the minimum required by any recognized professional standard (J.A. 28a-29a). Residents who develop aggressive maladaptive behavior are treated with drugs and physical restraints that interfere with the acquisition and practice of skills needed to overcome the aggressive behavior. The inadequacies of Pennhurst, therefore, deprive Pennhurst residents of habilitation "appropriate to [their] needs" under any conceivable interpretation of "appropriate."

Pennhurst's failure to meet the minimum physical care standards defined by Section 6010(3) is equally clear. Inadequate staff supervision permits food stealing (J.A. 34a-36a), so residents are not assured "a nourishing, well-balanced daily diet" (42 U.S.C. 6010(3)(B)(i)). Physical and chemical restraints are used as substitutes for habilitation programs and in amounts that interfere with habilitation, in violation of Sections 6010(3)(B)(ii) and (iii). See J.A. 29a-33a. And Pennhurst never has met applicable standards for building safety (J.A. 19a-20a n.14), as required by Section 6010(3)(B)(iv).[52]

On this record, the relief approved by the court of appeals is appropriate and well within the court's power to remedy the "flagrant violation" (J.A. 47a)

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[52] Although the district court made no findings on Pennhurst's policy regarding visits by relatives (see 42 U.S.C. 6010(3)(B)(v)), its isolated location and the large geographic area from which its residents are drawn (J.A. 14a, 19a) make family visits difficult—43% of the residents had had no family contact within three years of trial (J.A. 20a).

of the rights of Pennhurst residents. The court of appeals carefully followed judicial precepts and the commands of the statutes in tailoring its relief. It properly limited its remedy to curing the conditions that offend the statute. *Milliken* v. *Bradley*, 433 U.S. 267, 279-288 (1977).[53] The court of appeals thus approved only those parts of the district court's order that were designed to protect and secure the rights of Pennhurst residents to habilitation appropriate to their individual needs.[54]

The court of appeals based its ruling "on the *nature* of the rights being enforced in this case" (J.A. 156a). The central objective of its remedy is the same as the objective of Section 6010: to create a mechanism for ensuring that each individual patient receives "treatment, services, and habilitation which [are] appropriate to [his] needs" 42 U.S.C. 6010(3)(A). The court of appeals sanctioned the use of a master to monitor the "complex and lengthy process" (J.A. 148a) of providing each Pennhurst resident with an appropriate habilitation plan. The court of appeals noted that this procedure was designed to give all parties an opportunity to partici-

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[53] Petitioners' argument that the remedy should have been limited to terminating federal funds to Pennsylvania (Br. 34-39) ignores the equitable discretion of the courts to effectuate the purposes of the statute. Cf. *Cannon* v. *University of Chicago, supra*, 441 U.S. at 704-706; *Regents of the University of California* v. *Bakke*, 438 U.S. 265, 419-420 n.26 (1979) (Stevens, J., concurring).

[54] The district court's order to provide alternative employment for Pennhurst employees was reversed because it was not "reasonably related" to providing appropriate habilitation (J.A. 153a).

pate in the development of habilitation plans (J.A. 151a) and was imposed by the district court only after Pennhurst officials had refused to devise and present their own remedies (J.A. 150a).[55]

While the court of appeals did not find "clearly erroneous the trial court's determination that, for the retarded class members as a whole, Pennhurst cannot be an appropriate setting in which to provide habilitation" (J.A. 156a), it reversed the district court's order prohibiting any institutional placement. Although the court of appeals read the Act as creating a strong presumption against such placements, it concluded that the statutory requirement for individualized habilitation plans prohibited a *per se* rule against all institutional placements.

The court of appeals' finding of a statutory preference for community living arrangements is clearly

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[55] Petitioners in No. 79-1404 question the propriety of the use of a master (No. 79-1404 Pet. 3, 16-17). Petitioners' discussion in their joint brief on the merits of their objections to the relief ordered is limited to the contention that the only relief that could properly be awarded is the termination of federal funding (Br. 34-39). In any event, the appointment of the master violates neither Rule 53, Fed. R. Civ. P., nor principles of federalism. It is common and entirely proper for courts to employ masters to assist them in devising the specific and necessary measures to effect a complex remedy. *E.g.*, *Gary W.* v. *Louisiana*, 601 F.2d 240, 244-246 (5th Cir. 1979); *Morgan* v. *Kerrigan*, 530 F.2d 401, 427 (1st Cir.), cert. denied, 426 U.S. 935 (1976); *Cruz* v. *Hauck*, 515 F.2d 322, 328-331 (5th Cir. 1975), cert. denied, 424 U.S. 917 (1976); *Davis* v. *Watkins*, 384 F. Supp. 1196 (N.D. Ohio 1974); *Pennsylvania Ass'n for Retarded Children* v. *Pennsylvania*, 334 F. Supp. 1257 (E.D. Pa. 1971); *Hart* v. *Community School Bd. of Brooklyn, N.Y., School Dist. #21*, 383 F. Supp. 699, 766-767 (E.D. N.Y. 1974).

correct.[56] The device of employing a presumption against institutionalization is not only a reasonable means of implementing this statutory preference, it is also entirely consistent with the factual record in this case.[57] That presumption will ensure that only those persons whose disabilities require institutionalization in a facility like an "improved" Pennhurst will be placed there; and it will fulfill the obligation of the state and federal governments not to support institutions that do not provide treatment "appropriate" to the needs of the persons in them. Cf. 45 Fed. Reg. 31014 (1980). (Proposed Health and Human Services Regulations to implement Developmentally Disabled Assistance and Bill of Rights Act). In contrast, an order like that suggested by the dissent below (J.A. 163a), requiring the State to transform Pennhurst into a suitable place for habilitation for the full range of mentally retarded persons currently residing there, would be insufficient for several reasons.

Improvement of Pennhurst would not adequately address the individual needs of persons who should be in community living arrangements. For them, even an improved Pennhurst would not be an appropriate placement (J.A. 157a). Indeed, no pro-

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[56] The Senate Committee which reported the original "Bill of Rights" expressed its strong disapproval of placing mentally retarded persons in institutions unnecessarily, endorsed the principle of "normalization", and cautioned that its specification of standards for institutional care where it is found necessary should not be construed as support for unnecessarily placing mentally retarded persons in institutions. S. Rep. No. 94-160, *supra*, at 33-34. The compromise bill that was enacted retained the preference for treatment in the least restrictive environment (42 U.S.C. 6010(2)).

[57] The evidence in this record summarized by the district court (J.A. 18a-40a) shows that confinement in a large, iso-

fessional person, including state officials responsible for Pennhurst, argued that anyone at Pennhurst needs to be there, cf. *Parham* v. *J.R.*, 442 U.S. 584 (1979).[58] On the contrary, the superintendent of the institution agreed that "it would be to the advantage and benefit of [Pennhurst's] retarded population * * * to be serviced in a community setting" (Tr. 22-171 to 22-172). The uniform opinion of the professionals qualified as experts in the field of mental retardation was that Pennhurst could not, as a practical matter, be made a suitable place for habilitation (Tr. 2-95 to 2-96; 13-116 to 13-131; 14-5 to 14-10; 22-171 to 22-172).

Moreover, the state had itself selected the option of phasing Pennhurst out, rather than attempting to transform it into an appropriate habilitation facility. The state legislature had already directed the construction of alternative living arrangements with the aim of decreasing the number of residents at Pennhurst.[59] The defendants themselves planned to close Pennhurst eventually, on an indefinite schedule that contemplated the removal of all residents from Pennhurst by the early 1980's (J.A. 42a, 78a). While state policy choices should not be controlling where violations of federal rights are found, deference to state policies and plans is a proper consideration for federal courts in devising a remedy when the state policies are consistent with congressional objectives.[60]

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lated institution like Pennhurst generally harms, rather than helps, the person confined.

[58] In contrast to Pennhurst, the mental hospital involved in *Parham* was "well staffed and well-equipped." 442 U.S. at 616, 618, 597-598.

[59] At trial time, $18 million of the money appropriated by the legislature for this endeavor remained unspent (J.A. 44a).

[60] In addition, deference to state policies avoids the necessity of "second guessing" state professional opinion. See,

In sum, the remedy required by the court of appeals was appropriately tailored to remedy the statutory violations proved in this record.

IV. THE COURT OF APPEALS' APPLICATION OF PENNSYLVANIA LAW WAS CORRECT AND SUPPORTS THE REMEDY HERE

Pennsylvania statutes impose a duty on defendants to "assure within the State the availability and equitable provision of adequate * * * mental retardation services for all persons who need them." Pa. Stat. Ann. tit. 50, § 4201 (Purdon 1969). The words of the statute are not ambiguous. See *In re Joyce Z*, 4 Pa. D. & C.3d 596 (Allegheny County C.P. 1975); cf. *Hoolick* v. *Retreat State Hospital*, 354 A.2d 609 (Pa. Commw. Ct. 1976), aff'd, 382 A.2d 739 (Pa. 1978). Petitioners' argument that state statutes impose an obligation only to provide "food, shelter, medical care and supervision" (Br. 42) is amply answered by the opinions of the court of appeals and the district court. See *Huddleston* v. *Dwyer*, 322 U.S. 232, 237 (1944); *Estate of Spiegel* v. *Commissioner*, 335 U.S. 701, 707-708 (1949); cf. *Eubanks* v. *Clarke*, 434 F. Supp. 1022, 1027 (E.D. Pa. 1977).[61]

Petitioners' obligation to undertake the habilitation of retarded persons in Pennsylvania is thus not solely a matter of federal compulsion. Whatever options may be available to the state under federal

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e.g., *Bowring* v. *Godwin*, 551 F.2d 44 (4th Cir. 1977); cf. *Bell* v. *Wolfish*, 441 U.S. 520 (1979).

[61] Petitioners rely on the Pennsylvania civil commitment statute, Pa. Stat. Ann. tit. 50, § 4406(a) (Purdon 1969), which prescribes the standards for commitment of mentally retarded persons. This statute says nothing, however, about petitioners' duty to such persons once committed.

law to decline to undertake services to mentally retarded persons, see *Rosado* v. *Wyman*, 397 U.S. 397 (1970) (Pet. Br. 35-36), those options are not available to petitioners under Pennsylvania law. The decision below thus rests on an independent and adequate state ground, as we stated in opposing certiorari (Br. in Opp. 9-12). In any event, the pertinent requirements of state law were thus appropriately accommodated in the remedy devised by the court of appeals for the federal statutory violations found in this case.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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Nos. 79-1404, 79-1408, 79-1414, 79-1415, and 79-1482

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
Petitioners,

v.

TERRI LEE HALDERMAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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REPLY BRIEF FOR PETITIONERS

The briefs by respondents and the amici supporting them range far and wide, addressing many issues that do not bear on the disposition of this case. Thus, respondents and amici spend considerable time relating the historical shortcomings in the quality of care provided to the mentally retarded in this country,[1] and heralding

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[1] Even the lengthy discussions of conditions at Pennhurst are not legally relevant to this case. In reaching its decision, the Court of Appeals relied only on the limited factual finding that "in general institutions are less effective than community living

community-based treatment as the ultimate panacea. While there is disagreement over the desirable *extent* of community care as an alternative to institutional placements, *see* brief amici curiae by Congress of Advocates for the Retarded, *et al.*, there is no question that all parties to this litigation seek to enhance the lot of the mentally retarded. This Court, however, is not asked to decide how best to accomplish that goal. Rather, its sole task is to discern what, if any, legally-enforceable obligations the Developmentally Disabled Assistance and Bill of Rights Act imposes on the states, and what relief is appropriate to enforce any such obligations.

On those dispositive issues, respondents have far less to say, and what they do say is often mutually inconsistent. Thus, while the Halderman and PARC respondents apparently see the source of the legal obliga-

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arrangements in facilitating the right to habilitation in the least restrictive environment." 612 F.2d at 114; 155a. The court's decision and the obligations it imposes in no way depend on the factual circumstances concerning Pennhurst.

It should be noted in any event that, although there have been deficiencies at Pennhurst, "[a]ll parties concede that [Pennhurst] has undergone tremendous improvment since the 1950's . . ." 446 F.Supp. at 1302; 19a. Its population had been reduced from 4,000 in the early 1960's to 1,230 in 1977. *Ibid.* At the same time, its staff was increasing, numbering approximately 1,500 in 1977. Indeed, even respondents' witnesses admitted that Pennhurst had improved in some important areas: staff training (Roos 1-155); buildings (Roos 1-126); hygiene (Lowrie 4-53); clothing (Bowman 13-81); and generally (Dybwad 7-52).

Moreover, since the time of trial substantial additional improvements have been made in the physical plant as well as in the programs; the resident population has decreased below 1,000, while the size of the staff remains the same. The Special Master has documented these improvements by noting Pennsylvania's substantial compliance with the district court's specific orders relating to upgrading Pennhurst. *See* 446 F.Supp. at 1328-29; 85a-88a.

tions in § 6010(1) and (2) of the Act, the United States disavows reliance on § 6010(2), and looks instead to § 6010(3). Compare H. Br. at 41, and P. Br. at 13, with U.S. Br. at 16. Nor do respondents agree on the justification for applying § 6010 to Pennhurst, which admittedly does not receive DD Act funds. The Halderman respondents suggest the § 6010 applies to all mentally retarded people, irrespective of federal funding; the PARC respondents claim that it applies to retarded people in any program receiving any federal monies, regardless of source; and the United States asserts that it applies only to people who have been placed in institutional settings at federal and state expense. Compare H. Br. at 36-37, with P. Br. at 28, and U.S. Br. at 13-15. Similarly, while the first two respondents, for different reasons, believe that the Act requires Pennhurst to be closed altogether, the United States, in accord with the Third Circuit, disagrees. Compare H. Br. at 60 n.85, and P. Br. at 33-34, with U.S. Br. at 35. And, while the Halderman respondents and the United States argue that the district court (through utilization of a Master) should make individual placement determinations for each Pennhurst resident, the PARC respondents maintain that such determinations are not authorized by the Act and, in any event, are an improper exercise of judicial authority. Compare H. Br. at 61-63, and U.S. Br. at 33-34, with P. Br. at 32.

These divergent and contradictory approaches serve only to confuse the basic issue in dispute: Does the DD Act authorize a federal court to order Pennsylvania to provide community living arrangements (CLA's) for all Pennhurst residents (and others),[2] unless it can be shown that Pennhurst is preferable to the specific CLA designed for the individual in question. In our view,

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[2] *See* Argument III *infra*.

the Act plainly does not contemplate such an approach. On the contrary, first in 1975 and subsequently in 1978 Congress explicitly addressed the issue of the states' responsibility for developing CLA's, and adopted requirements that are far different from those mandated by the Court of Appeals. Moreover, even the specific statutory provisions relied on by respondents make clear that Congress at most intended to cut off federal funding to noncomplying states, not to authorize a federal takeover of state programs.[3]

I. THE DD ACT DOES NOT COMPEL THE WHOLESALE CREATION OF COMMUNITY LIVING ALTERNATIVES.

Although respondents insist that § 6010 of the DD Act compels states to establish CLA's for most, if not all, mentally-retarded persons, the fact is that § 6010 does not mention either CLA's or deinstitutionalization at all. Thus, any mandate for deinstitutionalization in § 6010's "findings" can be derived only by inference from general phrases like "appropriate treatment" or "least restrictive" setting. The initial, indeed dispositive, flaw in this analysis is that it simply ignores the sections of the DD Act in which Congress expressly dealt with the issue of deinstitutionalization and the obligation of the states to create CLA's.

The DD Act, as originally enacted in 1975, had specific language regarding the limited obligations of participating states to undertake deinstitutionalization. Section 6062(a)(4) expressly required each state to use not less than 10 percent of its 1976 allotment under the

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[3] We will also show that, in no event, can the relief below be affirmed insofar as it covers people not currently at Pennhurst, and that state law was misapplied by the courts below. Petitioner PPSA does not join in these latter two arguments, however.

DD Act, and not less than 30 percent in succeeding years, "for the purpose of assisting in developing and implementing plans designed to eliminate inappropriate placement in institutions of persons with developmental disabilities." 42 U.S.C. § 6062(a)(4) (repealed). Although this provision plainly demonstrated Congress' concern that the use of community facilities be increased, this experimental beginning is a very different matter from the compulsory transfer of every developmentally disabled person unable to defend his continued presence in an institution, the obligation that respondents purport to find in the Act. Indeed, were respondents correct, the provisions of § 6062(a)(4) would be meaningless because § 6010 would already have compelled the states to spend 100 percent of their allotment, and any other sums necessary, to correct for "inappropriate placement" of individuals in institutions. If this were the result that Congress had in mind, it chose a peculiarly oblique way of saying so.

The intent of Congress regarding CLA's became still more evident in 1978, when it amended the DD Act to relieve the states even of the modest duty imposed by the 1975 statute. Having had three additional years to consider the impact of its 1975 legislation, Congress struck from the statute any requirement that the states employ their allotments to support deinstitutionalization. Instead, Congress added a new section, 42 U.S.C. § 6063(b)(4)(A)(ii), which in essence required the states to concentrate their efforts in at least one of four priority service areas, including not only CLA's but also case management services, child development services, and nonvocational social-developmental services. 42 U.S.C. § 6001(8)(B). Thus, while states remained free to target funds for CLA's, they also retained the discretion to emphasize other priority areas if they deemed them more beneficial. Again, if § 6010 had already forced

CLA's upon the states for all but a few developmentally disabled persons, the policy choices contemplated by § 6063 would be illusory.

The legislative history of the 1978 amendments emphasizes the fact that states were to have substantial freedom in providing care for the developmentally disabled. Discussing the requirements of § 6063, which allowed the states to select areas of the highest priority to them, the relevant House Report noted that "it leaves the individual States some flexibility to choose the service areas in which Federal dollars are most needed. . . ." H.R. Rep. No. 1188, 95th Cong., 2d Sess. 10 (1978), *reprinted* in 6 [1978] U.S. Code Cong. & Ad. News 7355, 7364. The report further noted the preliminary nature of the DD Act, cautioning against "unrealistic expectations which cannot be fulfilled" and identifying the benefits of further study and "an orderly expansion of the program as Federal support increases in future years." *Ibid.* This restrained approach, of course, is difficult to square with the notion that Congress had already mandated CLA's for almost all developmentally disabled persons throughout the nation, regardless of the funds available or the priority choices that an individual state might make.

This is not a case, therefore, where the courts must divine what Congress would have done if some matter or other had come to its attention. Congress specifically spoke to the issue of CLA's in the DD Act, taking the position that they were to be a required, though limited, part of participating state programs in 1975 and, later, one of several opinions that the states might elect. At no time, however, did Congress order the states to implement CLA's as a final solution in most cases, nor insist that the states, as a price of participation in the DD Act, adopt one of many competing views about optimal care for the developmentally disabled.

Despite this straightforward treatment of CLA's in the DD Act, respondents nonetheless claim that § 6010 of the Act compels the states to place developmentally disabled persons in CLA's except in rare cases. According to respondents, the congressional findings that persons with developmental disabilities have "a right to appropriate treatment" (§ 6010(1)) and that the treatment "should be provided in the setting that is least restrictive of the person's personal liberty" (§ 6010(2)) embody a congressional mandate that CLA's replace larger facilities as a general rule. Even aside from the fact that it is inconsistent with § 6062 discussed earlier, this reading is insupportable.

To begin with, the language of § 6010 simply will not sustain it. Although respondents earnestly maintain that no language could make a clearer commitment to CLA's, the fact is that § 6010 does not contain one word about CLA's or deinstitutionalization. Had Congress wished to impose a massive federal requirement of CLA's on the states, it could have borrowed language from § 6062, ordering states to lessen "inappropriate placement in institutions," while making it clear that institutionalization was appropriate only in the exceptional case. Or it could have expressly provided that a state has a duty to provide CLA's unless it can demonstrate that institutional care would be preferable. It is doubtful at best that Congress would order substantial displacement of persons from institutions to CLA's without bothering to mention institutions or CLA's at all.[4]

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[4] Congress not infrequently makes broad declarations of policy without intending to create enforceable legal duties. *See, e.g.*, 42 U.S.C. § 3001 (cataloguing list of objectives concerning "older Americans"). When it intends to impose discrete legal obligations, by contrast, it speaks far more clearly, as it did in the several statutes that respondents mistakenly seek to analogize to the DD Act. *See, e.g.*, 29 U.S.C. § 794 ("No otherwise qualified handicapped individual . . . shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal

It is also suggestive that §§ 6010(1) and (2), by their terms, place no obligations on the states. Recognizing this fact, two respondents try to subsume the propositions of subsections (1) and (2) within the language of § 6010(3), which at least talks in terms of state (and federal) obligations. See P. Br. at 25-26 n.36; U.S. Br. at 16. But subsection (3) not only contains no language regarding CLA's or deinstitutionalization,[5] it even omits any mention of the "least restrictive" setting.[6] More-

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financial assistance"); 42 U.S.C. § 1973 ("No voting qualification or prerequisite to voting, or standard, practice, or procedure shall be imposed or applied by any State or political subdivision to deny or abridge the right of any citizen of the United States to vote on account of race or color"); 42 U.S.C. § 2000a(a) ("All persons shall be entitled to the full and equal enjoyment of the goods, services, facilities, privileges, advantages and accommodations of any place of public accommodation, as defined in this section, without discrimination or segregation on the ground of race, color, religion, or national origin"); and 42 U.S.C. § 2000d ("No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance").

[5] On the contrary, § 6010(3), by its terms, unmistakeably contemplates placements in "*institution*[*s*] [as well as] other residential program[s]." (Emphasis supplied.) Moreover, as the brief for the United States acknowledges, Congress realized that the standards contained in § 6010(3) "will not in themselves ensure quality habilitation and adequate treatment programs." H.R. Conf. Rep. No. 473, 94th Cong., 1st Sess. 43 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 943, quoted in Br. for U.S. at 22 n.37. For this reason, Congress made plain that § 6010(3) was not designed "to preempt or supplant any existing Federal or State standards currently in force (*e.g.*, standards applicable to Intermediate Care Facilities for the Mentally Retarded under Medicaid), which may require *more detailed or higher standards of care.*" *Ibid.* (Emphasis supplied.)

[6] As noted by the Halderman respondents, § 6010(3) speaks only to the standards generally governing institutions, not to the appropriateness of any *particular* individual's treatment. H. Br. at 41. For this reason alone, the bootstrap reliance on § 6010(3) as support for the mandate imposed below is misplaced.

over, it does not order the states to do anything, stating only that public funds should not go to substandard facilities and programs.

The legislative history further undercuts the idea of a hidden mandate in § 6010. Without repeating all the legislative history set out in our opening brief at pp. 18-21, it is enough to say that Congress did not intend to impose inflexible federal requirements on the participating states. Thus, for example, the House Report indicated only that states would have to "plan for as much deinstitutionalization as is feasible," further noting that the Act would "prompt some movement of patients from State institutions back into their communities." H.R. Rep. No. 58, 94th Cong., 1st Sess. 8 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 919, 928. Reviewing this legislative history, the dissent below stated: "I fail to see how a duty to 'support' 'feasible' non-institutional care can be elevated to an absolute duty to provide the least restrictive treatment for every individual regardless of cost or available resources." 612 F.2d at 118; 167a.

The United States, apparently recognizing these considerations, nevertheless maintains that, even though the DD Act does not contain a requirement for CLA's, their creation can be ordered as an appropriate remedy for violating *other* requirements. There is no basis for this curious argument.[7] The federal courts have no license

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[7] The position taken by the United States is especially surprising in view of its recognition of the limited purpose of § 6010(3) and its relationship to other statutes administered by the United States itself. *See* n.5 *supra*. The Department of Health and Human Services, for example, has promulgated detailed standards for any state facility seeking medicaid funding for its mentally retarded residents. *See* 42 C.F.R. § 442.400 *et seq*. Those medicaid standards clearly apply to institutions such as Pennhurst. *See* 42 U.S.C. § 1396d(c). Indeed, while Pennhurst gets no funds under the DD

to seize upon the violation of one section of a statute as a means to write in another section that Congress consciously excluded.[8] If a state may maintain institutions under the DD Act, the remedy for substandard institutions is *at most* an order to improve the institutions, not a complete reordering of the policies of state care.[9]

The courts below have simply rushed in where Congress declined to tread. Despite its initial desire for greater utilization of CLA's, Congress elected to move slowly in encouraging their creation, preferring to see results before embarking on a full-scale federal program. Considering the enormous dislocation that results from moving developmentally disabled persons from one facility to another, that course is a reasonable one for Con-

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Act, it receives substantial medicaid funding. In 1978-79, for example, it received more than $7 million of its $32 million budget from federal medicaid funds.

[8] Contrary to the suggestion by respondents, this is not a case where a court invokes its broad remedial powers to reverse a long-standing *constitutional* violation. Rather, the nature of any legal obligation and the concommitant scope of relief is dictated by the statute itself.

[9] The United States claims that "[i]mprovement of Pennhurst would not adequately address the individual needs of persons who should be in community living arrangements." U.S. Br. at 35. Without seeking to dispute the policy implications of this claim, we note simply that the DD Act does not require the states to assure that each person is placed in *the* preferred setting, even assuming such a concept could be implemented in a realistic fashion. Nor is it of any consequence in determining the propriety of relief that the state itself contemplated "the *option* of phasing Pennhurst out," U.S. Br. at 36 (emphasis supplied). An "option" available to a state is a far different matter from a judicial mandate eliminating not only a rethinking of options but also the state's timetable for implementing any option. It should be noted in this regard that Pennsylvania maintains a flexible position with respect to the future of Pennhurst. Surely the propriety of the relief should not depend on whether Pennsylvania ultimately decides, based on its further experience with CLA's, that an improved Pennhurst is the preferred option.

gress to take. It should not be set aside because others would have chosen to move faster.[10]

II. AT MOST, THE DD ACT CONTEMPLATES A FUND CUTOFF FOR NONCOMPLIANCE WITH THE ACT, NOT A FEDERAL TAKEOVER OF STATE PROGRAMS.

Even if the DD Act is read to require the widespread creation of CLA's, as respondents would have it, that obligation is not an absolute federal mandate, but rather a condition of receiving funds under the Act. It follows, then, that the proper remedy for noncompliance is a cutoff of funds, not the federalization of state programs.

The DD Act clearly belies the notion that Congress, in establishing a partnership with the states, intended the states to be only limited partners. Not only is the stated purpose of the Act to "assist States" in improving their own systems, § 6000(b)(1), but the Act repeatedly leaves the states substantial discretion in the development of their programs. *See generally* § 6063. Were this factor not enough, the Act contains a flat declara-

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[10] This is not to suggest that Pennsylvania has not been diligent in developing community facilities for the mentally retarded. Pennsylvania's community placement program was repeatedly described as excellent, even by respondents' experts (*see, e.g.*, Girandeau 5-139; Glenn 6-51, 6-69; Settle 6-168, 7-4). This program has placed many Pennhurst residents in the community (Billyew 24-51), and most of those residents have adjusted well (*see, e.g.*, Girandeau 5-170; Troester 588A; Hill 559A; Vaughn 603A; Auerbach 611A). The development of community placements is complex, however (Roos 1-205). Moreover, while experience with persons with lesser handicaps indicates that such placements may be cheaper than residential care, this will not necessarily be the case with the severely and profoundly retarded (Glenn 6-79). In any event, it is important to coordinate additional services with the provision of community residential placements (*see, e.g.*, Roos 1-207, Glenn 6-71, Settle 6-173, 7-20), something Pennsylvania has done well (Glenn 6-51, Settle 7-4), but which takes careful planning and monitoring.

tion that, "[e]xcept as otherwise specifically provided, nothing in this chapter shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance or operation of any facility" receiving funds under the Act. 42 U.S.C. § 6003. The federal supervision and control in this case is no more appropriate simply because it is initiated by a federal judge or master.

It is also important that § 6010(3) of the Act speaks only in terms of the proper utilization of public funds. Although Congress might have stated that every state program, regardless of whether it received any funds or not, should comply with the standards of that subsection,[11] it carefully conditioned any obligations on the use of public funds.[12] Indeed, Senator Schweiker, a co-sponsor of the Act, explained that § 6010 provides "protection *by denial of funds* to programs which do not provide appropriate treatment, services, and habilitation or meet appropriate standards." 121 Cong. Rec. 29, 820 (September 23, 1975) (emphasis supplied).[13]

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[11] Such legislation might raise serious constitutional questions, however. *See* brief amici curiae of Illinois, *et al.* at 33-37.

[12] The PARC respondents appear to suggest that § 6010(3) authorizes a fund cutoff of all federal monies received by the state for care of the mentally retarded, and that, as a practical matter, therefore, a fund cutoff would assure compliance with the substantive standards. P. Br. at 41 n.58. Even assuming, contrary to our position as set forth in our initial brief at pp. 14-23, that § 6010(3) creates enforceable duties, respondent is nevertheless in error. First, § 6010(3) explicitly limits any fund cutoff to the noncomplying institution, not to the entire state program. Hence, the dollar amount at issue is far more modest than respondent suggests. Second, irrespective of the amount at issue, Congress at most gave the states the choice of compliance *or* loss of funds. Respondent's view of the practicalities cannot displace the state's discretion in this regard. *See* Rosado v. Wyman, 397 U.S. 397 (1970).

[13] Section 6065 further provides that the Secretary of Health and Human Services can terminate a state's allotment under the

Although respondents claim that a fund cutoff would not be a sufficient remedy, that argument begs the question. Whenever Congress attaches conditions to a grant of funds, rather than imposing them on the states outright, it gives the states the option to accept both the funds and the conditions, or to accept neither. The courts below simply have eliminated the choice extended by Congress, ordering the states to accept the conditions regardless of their willingness to renounce the funds. That remedy does not effectuate the intent of Congress, it cuts it in half.

This Court has recognized these principles in *Rosado* v. *Wyman*, 397 U.S. 397 (1970), discussed in our main brief at 35-36. There, noting that New York had acted in violation of the federal welfare statute, the Court specifically found that "the state ha[s] alternative choices of assuming the additional cost" of complying with the statute, "or not using federal funds to pay welfare benefits according to a plan that [is] inconsistent with federal requirements." 397 U.S. at 420-21.[14] Here,

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DD Act for noncompliance with the general statutory standards, inincluding the requirement that state programs receiving DD Act funds protect the interests described in § 6010. *See* § 6063 (b) (5) (C). We note in this regard that Pennsylvania's allotment under the Act continues to be approved by HHS, despite the Justice Department's position in this case. *See also* n.7 *supra*.

[14] Respondents claim that Cannon v. University of Chicago, 441 U.S. 677 (1979), and Regents of the University of California v. Bakke, 438 U.S. 265, 419-420 n.26 (1978) (concurring opinion), justify a different result. Aside from the fact that the *Bakke* opinion was not an opinion for the Court, the statutes at issue in those cases specifically barred discrimination in university admissions, in addition to authorizing a fund cutoff by the federal government. The Court in *Cannon* found that Congress intended to allow specific enforcement of the anti-discrimination section, thus allowing courts to order the admission of applicants who demonstrate that they have been discriminated against. The limited intrusion of placing an applicant in an ongoing university program

assuming that the failure to develop CLA's—to an extent and in the fashion dictated by the court below—is inconsistent with the conditions imposed by the DD Act, the states have the same choice: comply with the conditions or get out of the federal program. The federal courts are not privileged to force a preferred choice upon them.

III. IN NO EVENT CAN THE RELIEF BELOW BE AFFIRMED INSOFAR AS IT APPLIES TO PERSONS NOT CURRENTLY AT PENNHURST.

Even assuming that § 6010 imposes an enforceable obligation on the states to create CLA's, the judgment below still went too far in that it affirmed relief covering not only Pennhurst residents, but also others on the waiting list, as well as those not even on the waiting list but who "may become residents of Pennhurst." 446 F.Supp. at 1300 and 1326; 14a and 79a-80a.[15] *See also* 612 F.2d at 115; 159a (rights extend to "future applicants" for services). These aspects of the judgment below were plainly without legal basis.

All the briefs in this case recognize that Congressional concern in the DD Act focused on the residents of state institutions and the conditions they faced. No simple equation can be made between these people and the mentally retarded in general, however. Many mentally retarded citizens live with parents or other family members or relatives, some live with friends or guardians,

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was found compatible with the purposes of the Act. The matter is far different here where respondents would have a court force the states to create new facilities for the retarded.

[15] There are approximately 2,000 people currently on the waiting list for Pennhurst. These people are not now in state or county custody.

still others live alone, and some reside in privately-operated facilities. To read § 6010 as creating an absolute right to state-funded treatment for all such people would have staggering implications. It is one thing to say that a state has the obligation to afford appropriate services to those in its custody;[16] it is quite another to say that the state has a privately enforceable federal duty to provide such services to the "more than two million persons with developmental disabilities in the United States." 42 U.S.C. § 6000(a)(1). Nothing in the DD Act or its legislative history suggests that the Congress intended to place such an enormous open-ended obligation on the states' fisc.

We pointed out in our main brief at 36-37 n.57 that if § 6010 imposed the obligations declared by the court below, such an enactment would exceed the constitutional limits of Congress' power either under the Spending Clause or under Section 5 of the Fourteenth Amendment. The court below disagreed, claiming that the DD Act contained a sufficient Section 5 constitutional predicate in that it was intended "to enforce recognized constitutional rights. . . ." 612 F.2d at 98 n.17; 117a n.17. In this regard, the court cited *Ingraham* v. *Wright*, 430 U.S. 651, 673 (1977), as support for a Fourteenth Amendment right "to be free from and to obtain judicial relief for unjustified intrusions on personal security." 612 F.2d at 98; 117a.

But whatever minimal plausibility *Ingraham*, or *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972) (the right to a commitment whose nature and duration bears some reasonable relationship to its purpose), or *O'Connor* v. *Donaldson*, 422 U.S. 563, 576 (1975) ("a State cannot constitutionally confine without more a nondangerous

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[16] The focus of the Act, and of § 6010 in particular, is to help provide *appropriate* treatment for those already *receiving* treatment

individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends"), might have with respect to the rights of mentally retarded persons in state institutions,[17] the argument does not extend to the vast majority of the developmentally disabled who live at home or in other private placements. They have not been deprived of their liberty by the state, nor are they subject to any unjustified intrusions on their personal security at the hands of the state. With respect to such privately situated persons, there is no Fourteenth Amendment right to enforce and, therefore, no Section 5 predicate. Indeed, even the district court, which found in favor of respondents on virtually every legal theory they proffered (except, notably, the DD Act), acknowledged, "No constitutional mandate has been called to our attention which would require a state to provide habilitation for its retarded citizens." 446 F. Supp. at 1318; 60a.

Not surprisingly, respondents have scrupulously avoided discussing those aspects of the relief relating to persons not currently at Pennhurst. In fact, the United States specifically claims that this case is limited to mentally retarded persons "who have been placed in institutions at federal and state expense, . . ." U.S. Br. at 14; *see also id.* at 15 n.26. In view of these considerations, this Court, irrespective of any other conclusions it might reach, should vacate the relief insofar as it applies to people not currently at Pennhurst.

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[17] It should be noted in this regard that *no* federal court, except the district court in this case, has ever ordered deinstitutionalization as a constitutional remedy in a disputed case involving treatment of the retarded in state institutions. See brief amici curiae of Illinois, *et al.* at 33-37.

IV. THE ERRONEOUS INTERPRETATION OF STATE LAW BY THE COURT OF APPEALS IS BASED ON A CLEARLY IMPROPER APPLICATION OF PENNSYLVANIA'S RULES OF STATUTORY CONSTRUCTION.

Respondents assert that this Court should defer to the Court of Appeals interpretation of state law and that, in any case, the lower court's interpretation was correct and provides an independent basis for the decision below. We have already dealt with the last two arguments at length, showing both that the interpretation of state law was erroneous and that, in any event, the Court of Appeals itself made clear that state law did not provide a sufficient basis for its judgment. Pet. Br. at 39-43. Respondents' claim that this Court should defer to the court below's reading of state law is equally without merit. While it is true that the Court generally defers to a lower federal court's interpretation of local law, such deference is inappropriate when that interpretation is plainly wrong. It is even less justified when the lower court has clearly misapplied state rules of statutory construction.

In this case, the court below relied heavily on legislative debate in supporting its conclusion that Pennsylvania law creates a "right to treatment." This reliance was in clear violation of Pennsylvania's rules of statutory construction. Under Pennsylvania law, the remarks of individual legislators in debate are not part of the legislative history and are, therefore, not relevant to the meaning of a statute. *City of Philadelphia* v. *Depuy*, 431 Pa. 276, 244 A.2d 741 (1968); *Zemprelli* v. *Thornburgh*, 47 Pa. Cmwlth. Ct. 43, 407 A.2d 102 (1979). This error seriously undermines the validity of the lower court's analysis and requires review by this Court.

CONCLUSION

The decision of the Court of Appeals should be reversed.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
Petitioners

v.

TERRI LEE HALDERMAN, *et al.*,
Respondents

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

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QUESTIONS PRESENTED BY AMICUS

1. Whether mentally retarded persons have a privately enforceable right to receive appropriate treatment, services, and habilitation in a setting that is least restrictive of personal liberty when in the custody of a state receiving federal funds under the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§ 6000 *et seq.*

2. Whether 42 U.S.C. § 1983 provides a remedy to enforce the provisions of the Developmentally Disabled Assistance and Bill of of Rights Act, 42 U.S.C. §§ 6000 *et seq.*

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BRIEF OF THE AMERICAN BAR ASSOCIATION AMICUS CURIAE

INTEREST OF AMICUS CURIAE

The American Bar Association is a national membership organization of the legal profession. It counts as members more than 260,000 lawyers from all states and the District of Columbia and has, since 1944, maintained an active interest in the field of mental disability law.[1]

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[1] The Association established a Special Committee on the Rights of the Mentally Ill 36 years ago; this committee's recommendations

This interest was expanded in 1973 when the Board of Governors of the American Bar Association established a Commission on the Mentally Disabled, a 17-member interdisciplinary body charged with promoting effective legal assistance to the mentally disabled and with recommending and implementing programs designed to correct pervasive deficiencies in the nation's mental disability system.

Since its inception, the Commission on the Mentally Disabled has focused its efforts toward, *inter alia*: mobilizing, activating, and awarding grants to local and state bar associations to encourage legal representation of the mentally disabled (including appropriate substantive technical assistance); establishing and publishing the *Mental Disability Law Reporter*, an interdisciplinary journal which reports significant developments in the mental disability law field; operating a resource center to aid legal research; and developing model legislation to assist states in revising and updating their statutes dealing with the mentally retarded and other developmentally disabled persons.

The Commission on the Mentally Disabled has been active in shaping Association policy with respect to the mentally disabled. Pursuant to a Commission recommendation, the Association's House of Delegates adopted in August, 1978, a policy statement calling for, among other things, enforcement of "existing laws and regulations which prohibit discrimination against mentally disabled persons . . . ," and state protection of "a right of treatment/right to habilitation" and of "a right to treatment in the least restrictive setting" (see Appendix A).

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led ultimately to the publication of a number of path-breaking studies by the American Bar Foundation, created by the Association in 1952. *See* Lindman & McIntyre, *The Mentally Disabled and the Law* (1961); Rock, Jacobson, & Janopaul, *Hospitalization and Discharge of the Mentally Ill* (1968); Matthews, *Mental Disability and the Criminal Law* (1970); Brakel & Rock, *The Mentally Disabled and the Law* (rev. ed. 1971).

The House of Delegates also adopted a resolution sponsored by the Commission on the Mentally Disabled in August, 1977, which "urges the swift and effective implementation of federal laws and regulations codifying the rights of mentally handicapped persons. . . ." (see Appendix B). Thus, the Association has special experience and particular interest in the question now before the Court.

With due consideration of the extended factual and legal analysis offered in the briefs of the parties and other *amici*, the Association, with the written consent of the parties,[2] sets forth its views herein on the important question of whether mentally retarded persons have a judicially enforceable statutory right to habilitation in the least restrictive setting.

STATEMENT OF THE CASE

On May 30, 1974, a class action lawsuit was filed in the United States District Court for the Eastern District of Pennsylvania by Terri Lee Halderman and other mentally retarded residents of Pennhurst State School and Hospital alleging that they were subject to chronic abuse and neglect (resulting in intellectual and physical regression), lack of supervision, inhumane and dangerous conditions, and nonexistent opportunities for appropriate community care. See 15a, 94a-95b. Violations of constitutional as well as federal and state rights were alleged.

The Parents and Family Association of Pennhurst was added as plaintiff on July 29, 1974. The United States was granted leave to intervene as plaintiff on January 17, 1975, and the Pennsylvania Association for Retarded Citizens was similarly granted leave to intervene

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[2] Copies of letters indicating the parties' consent have been filed with the Clerk of the Court.

on November 12, 1975. The certified plaintiff class consists of all persons "who . . . have been or may become residents of Pennhurst." 14a, 96a.

After a thirty-two day trial, the District Court ruled that the conditions at Pennhurst were so inadequate and debilitating that plaintiffs had been denied their rights under the Due Process Clause, the Equal Protection Clause, Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), and the Pennsylvania Mental Health and Mental Retardation Act (Pa. Stat. Ann. tit. 50, § 4201 *et seq.* (Purdon 1969)). Despite three opportunities, defendants failed to submit a plan for the implementation of these rights, and on March 17, 1978, the trial court entered its judgment for plaintiffs, ordering interim steps for the improvement of conditions at Pennhurst and the development of plans for the closing of Pennhurst itself and the removal of its residents to more appropriate, less restrictive community living arrangements.

Defendants filed appeals to the Court of Appeals for the Third Circuit and on December 13, 1979, that court affirmed the District Court's findings of liability. Specifically, the *en banc* Court of Appeals held that defendants' actions violated both the Developmentally Disabled Assistance and Bill of Rights Act (42 U.S.C. §§ 6001-6081) and Pennsylvania statutes (Pa. Stat. Ann. tit. 50, §§ 4201 *et seq.* (Purdon 1969)). The court condemned the "abominable" conditions at Pennhurst (103a), with the dissenting judges acknowledging those "deplorable conditions" (162a). Because of Pennhurst's shortcomings and the fact that many of its residents could immediately be moved into the community, the Court of Appeals held that the Commonwealth must determine on a case-by-case basis which individuals could be appropriately cared for at an improved Pennhurst, and which should be placed in the community. 157a.

The Court of Appeals avoided the constitutional issues addressed by the District Court by finding an enforceable right to habilitation under federal law. The court also relied on state statutes and case law to find a right to habilitation.

SUMMARY OF ARGUMENT

Developmentally disabled persons were granted a number of important new rights by Congress when it enacted the Developmentally Disabled Assistance and Bill of Rights Act in 1975. Paramount among these are the right to appropriate treatment, services, and habilitation, and the right to receive such treatment in the least restrictive setting—all of which were enacted in conjunction with a national policy change embracing deinstitutionalization. These rights vest personally in the developmentally disabled, unlike other rights created by the statute which operate only as conditions of fiscal performance under the Act.

A close reading of the language of the pertinent provisions of the Act, an examination of its overall structure, and a thorough review of its legislative history reveal the fundamental nature of these rights. The Commonwealth of Pennsylvania bound itself to the observance of these rights upon agreeing to participate in the Act's programs. This would be true whether one concludes Congress acted to implement the Fourteenth Amendment pursuant to Section 5 or to provide for the general welfare pursuant to Article I, Section 8.

This Court has recently ruled that in the case of the Social Security Act, federal statutory rights may be enforced by way of private right of action under 42 U.S.C. § 1983. The Developmentally Disabled Assistance and Bill of Rights Act establishes rights even more worthy of enforcement under § 1983.

ARGUMENT

I. The United States Congress Granted Mentally Retarded Persons the Right to Appropriate Treatment and Habilitation in the Least Restrictive Setting Under the Developmentally Disabled Assistance and Bill of Rights Act.

The numerous deficiencies of Pennhurst are not substantially different in kind or magnitude from those found at other large institutions throughout the country. The horrid results produced by our institutions are part of a system which has tried to deliver vital services to developmentally disabled people in isolated, dehumanizing settings which encourage personal abuses.[3] The severity of the problems is precisely why Congress felt so compelled to act to protect the interests of institutionalized developmentally disabled persons on a national scale.

This Court itself has recognized the destructive power of isolation and has unquestionably stimulated congressional investigations of civil institutions. *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975), put an end, at least as a legal practice, to institutional warehousing of nondangerous individuals who could live in less restrictive surroundings with the assistance of friends, relatives and the community. A similar principle was upheld recently in *Parham* v. *J.L.*, 442 U.S. 584 (1979), a case which recognized the need to constitutionally guarantee that mentally retarded children, like their adult counterparts, are "free of unnecessary bodily restraints" (*Id.* at 601) and are "not being labeled erroneously" (*Id.* at 601), two familiar practices in institutional settings.

Congress chose to address these problems for developmentally disabled people not with a "neutral factfinder," which is the minimal constitutional protection necessary

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[3] *See, e.g.*, Rothman, David J. *The Reform of the Asylum: Between Conscience and Convenience in Progressive America* (1980).

for children (*Id.* at 606), but with a bill of rights which includes individual legal redress when those rights are violated. Moreover, because of the intensity of past abuses, Congress prefaced those rights with a rebuttable presumption that deinstitutionalization is preferred.

The rights of mentally retarded and developmentally disabled people[4] have been the focus of congressional concern for a number of years. As early as 1963, Congress saw fit to enact funding legislation aimed at protecting such rights by the creation in the states of facilities and services that would adequately meet the needs of these people. Mental Retardation Facilities and Community Mental Health Centers Construction Act, *P.L. 88-164*, 77 Stat. 282, 88th Cong. (1963). This approach was furthered by congressional refinements adopted in 1967 and 1969. Mental Retardation Amendments of 1967, *P.L. 90-170*, 81 Stat. 527, 90th Cong. (1967), extended by the Developmental Disabilities Services and Facilities Construction Act, *P.L. 91-517*, 84 Stat. 1316, 90th Cong., 1st Sess. (1969).

Congress redirected its concern for the proper care and training of the developmentally disabled in 1975 by enacting the Developmentally Disabled Assistance and Bill of Rights Act (hereinafter "the Act"), 42 U.S.C. §§ 6000 *et seq.* The Act changed the previous patterns of federal funding by adding the Bill of Rights provision at issue in this case, 42 U.S.C. § 6010, and thereby fundamentally altered the manner in which federal and state units of government would serve the mentally retarded.

This evolution in congressional approach, from the straightforward provision of funds for facility construction to the emphasis on mandatory rights set forth in the

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[4] The term "developmental disability" is defined at 42 U.S.C. § 6001(7) and includes such conditions as mental retardation, cerebral palsy, epilepsy, autism, and learning disabilities.

federal statute, itself suggests the magnitude and persistence of the nation's failure to humanely care for its developmentally disabled citizens.[5] And it is this failure that motivated the drafters of the Act to establish certain rights and guided them in their specific formulation.[6]

A. *These Rights are Clearly Set Forth in the Language and Structure of the Act Itself.*

At the outset, it should be noted that the very name of the Act, the "Developmentally Disabled Assistance and *Bill of Rights Act*" (emphasis added), reflects the extent to which Congress was moving beyond a limited funding statute. Every state considering participating in the program set up under the Act was surely on notice that part of the bargain would be mandatory protection of a certain number of "rights" considered important by Congress.

The actual Bill of Rights provision of the Act, 42 U.S.C. § 6010, expressly applies to "persons with developmental disabilities"; no additional limitations are set forth. The Act declares that such persons:

> have a right to appropriate treatment, services, and habilitation for such disabilities. [§ 6010(1).]

It goes on to define and specify the content of that right in the very next subsection:

> The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty. [§ 6010(2).]

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[5] 42 U.S.C. §§ 6001 *et seq.*, P.L. 94-103, 89 Stat. 502, 94th Cong., 2d Sess. (1975), amended, P.L. 95-602, 92 Stat. 2955, 95th Cong. (1978). See S. Rep. 94-160, 94th Cong., 1st Sess. 28-34.

[6] S. Rep. 94-160, 94th Cong., 1st Sess. 28-34 (1975).

Thus, at the beginning of the Act's Bill of Rights stands the clearly stated principle that mentally retarded persons are entitled to appropriate treatment [7] with minimum encroachment upon personal liberty.[8] Read together, subsections (1) and (2) represent an unequivocal statement by Congress of the overall spirit of this statute and of the most basic rights owed to developmentally disabled persons.

Congress' intent is further clarified by subsection (3), which proceeds to define how public funds are *not* to be used insofar as the developmentally disabled are concerned. The obligation of both the federal and state governments is "to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that (A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons. . . . § 6010(3).[9]

Congress obviously decided it was necessary to repeat the requirement for "treatment, services, and habilitation" in the context of governmental duties arising out of the use of "public funds," even though this already had been stated in the immediately preceding subsections.

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[7] The Act, reflecting accepted practice in the developmental disability field, distinguishes between treatment, which applies to curable mental illness, and habilitation, which consists of education and training for those, such as the mentally retarded, who are in no sense ill. The legal right is identical for each, and for that reason the terms are used interchangeably herein.

[8] The Association's House of Delegates has adopted a policy specifically endorsing both the right to treatment in the least restrictive setting. (For the full text of this policy, see Appendix A to this brief).

[9] Subsection (B) sets forth six minimum standards for institutional or residential programs, covering diet, medical care, use of physical restraints, use of chemical constraints, visitation, and fire and safety. 42 U.S.C. § 6010(3)(B).

The mildest deference to the plain language used in these lines forces one to acknowledge that subsections (1) and (2) establish rights inherent in the developmentally disabled person, while subsection (3) creates rights available only where government funds have become directly involved.[10] The Court of Appeals, in reviewing these subsections, observed:

> It is hard to see how Congress could have been any more precise in revealing its intention to confer a right to treatment or habilitation. 612 F.2d 84, at 96.

But Congress did endeavor to be more precise in 1978, when it supplemented the Bill of Rights with the following:

> The rights of persons with developmental disabilities described in findings made in this section are in addition to any constitutional or other rights otherwise afforded to all persons. [*P.L. 95-602*, Title V, § 507, 92 Stat. 3007 (Nov. 6, 1978).]

Only by the gross distortion of ordinary English could this provision be read to suggest anything but that Congress was intentionally establishing new rights in § 6010. By adding this sentence, Congress eliminates any doubt that subsection (1) and (2) rights are in fact personal rights of the developmentally disabled themselves.

The dichotomy of § 6010, with its creation of basic personal rights separate from conditions running only with the flow of public funds, is also present in the Act generally. For instance, Subchapter III of the Act, 42

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[10] *See* H. Conf. Rep. 94-473 at 42, reprinted at [1975] U.S. Code Cong. & Ad. News 943, 961. Under the approach taken by Congress, any facility failing to provide a "nourishing, well-balanced daily diet," as required by § 6010(3)(B)(i), for instance, would face loss of public funds. However, residents of that facility would still retain those rights set forth in § 6010(1) and (2).

U.S.C. §§ 6061-6068, creates a program for the distribution of federal funds to states for developmental disability services. Each section contains detailed and specific requirements and mechanisms by which allotments to states for planning, construction, administration, and services are to be made. Clearly, the Congress is not hesitant or obscure when it intends specifically to condition the use of its money under the Act. Such unmistakable conditions are glaringly absent from subsections (1) and (2) of § 6010.

The heart of the funding portion of the Act, however, concerns the preparation and submission of state plans. Any state wishing to participate under Subchapter III must submit a plan for the provision of services and facilities for persons with developmental disabilities to the Secretary of HEW [11] which must address numerous "conditions for approval." 42 U.S.C. § 6063(b). Furthermore, each state must create a state planning council of specified composition which, among other things, must "supervise the development of and approve the State plan . . ." 42 U.S.C. § 6067(b)(1). Where federal funds are concerned, the Act is replete with specific conditions and restrictions placed on the states by Congress.

Elsewhere in the Act, Congress has required that as a condition to receiving an allotment, states must have an individual habilitation plan for each developmentally disabled person served thereunder. 42 U.S.C. § 6011(a). Again, Congress demonstrated its capability of linking conditions to use of its funds when it so desired. The Bill of Rights found in the preceding section of the Act, § 6010, particularly subsections (1) and (2), contains no such restriction.

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[11] The Department of Health and Human Services is the successor agency to the Department of Health, Education and Welfare. 20 U.S.C. § 3508.

Finally, the Act's program for "protection and advocacy of individual rights" affirms the distinction the Act maintains between enforcement and funding provisions. 42 U.S.C. § 6012. Itself a condition to the receipt by a state of its allotment under the Act, the program is independently funded and invested with the authority to "pursue legal, administrative, and other appropriate remedies to insure the protection of the rights of such persons who are receiving treatment, services, or habilitation . . ." 42 U.S.C. § 6012(a)(2)(A). This authority taken with the section's requirement that the program be "independent," unmistakably indicates that Congress did not intend merely to police state compliance with spending conditions, but to ensure that actual legal rights were enforced.

B. *The Legislative History of the Act Reveals Congress' Intent to Establish These Rights.*

The policy shift which supports deinstitutionalization is not an isolated preference by Congress limited to developmentally disabled individuals or the Developmental Disabilities Act. Several other important federal programs demonstrate the existence of a national deinstitutionalization movement during the 1970s.

According to a government report,[12] Title XIX of the Social Security Act (Medicaid), 42 U.S.C. §§ 1396, *et seq.*, is "one of the most important factors affecting deinstitutionalization." In recent years the thrust has been to establish community alternatives such as the intermediate care facilities for the mentally retarded (ICF/MR).

Under Title XX of the Social Security Act, 42 U.S.C. §§ 1397 *et seq.*, Congress has stated that one of its major

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[12] Government Accounting Office Report to Congress: Returning the Mentally Disabled to the Community, HRD-76-152A (Jan. 7, 1977).

goals was "preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care." The implementing regulations, which are based in large measure upon the legislative history, prescribe that Title XX funds "only be used to encourage the development of safe and appropriate residential settings as an alternative to institutional living for appropriate elderly individuals and handicapped children and adults. . . ." 43 Fed. Reg. 4016 (1978).

Section 504 of the Rehabilitation Act, 29 U.S.C. § 794, while encompassing all kinds of discrimination against the handicapped, evidences a particular concern in its legislative history against segregation of handicapped individuals into isolated institutions. [1978] U.S. Code Cong. & Ad. News 7312.

Finally, the Community Mental Health Centers Act, 42 U.S.C. §§ 2689 *et seq.*, was enacted to establish community mental health centers as alternatives to isolated state institutions.

It is in this context that the Developmental Disabilities Act was proposed, and it is in this context that it should be read.

The fundamental focus of the Developmentally Disabled Assistance and Bill of Rights Act, if not obvious after a close reading of its many provisions, is revealed clearly in the legislative history.

Senator Harrison Williams, in supporting the House-passed version of the proposed Act (introduced in the Senate as S. 462), observed:

> While much can be said about the lack of available funds to improve conditions at these institutions, at some point this country must draw the line. The abuses are too commonplace to point at a single in-

> stitution, or a single abuse and say that it is an anomaly. [121 Cong. Rec. at 16516-17 (1975).]

The Senate Committee stated its understanding as follows:

> The Committee is firmly convinced that Congress must take action to ensure the humane care, treatment, habilitation and protection of the mentally retarded. The Federal Government has the responsibility to provide equal protection under the law to all citizens. [S. Rep. 94-160 at 32 (1975).]

Senator Jacob Javits described the public responsibility more bluntly:

> Congress should provide the leadership to change the tragic warehousing of human beings that has been the product of insensitive Federal support of facilities providing inhumane care and treatment of the mentally retarded. [121 Cong. Rec. at 16519.]

The virulence of this scandal was not easily checked, and during consideration of amendments to the Act in 1978, Senator Edward Kennedy felt compelled to observe:

> Mr. President, this is a program which I think is strongly needed. I do not know how many times we have had television documentaries on Willowbrook, and Forest Haven, and other institutions in this Nation, and still nothing gets done. [124 Cong. Rec. S15663 (daily ed. September 21, 1978).]

The approach chosen by the Congress was not merely to throw more money at the problem, but to end the discrimination as a matter of law. The remedy was to establish clear and definite rights, 42 U.S.C. § 6010, and to provide a mechanism for their enforcement, 42 U.S.C. § 6012. The rights established were meant to be commensurate with the seriousness of the inequity:

> These rights are generally included in the conference substitute in recognition by the conferees that the

> developmentally disabled, particularly those who have the misfortune to require institutionalization, have a right to receive appropriate treatment for the conditions for which they are institutionalized, and that this right should be protected and assured by the Congress and the courts, H.R. Conf. Rep. 94-473, 42 (1975), [1975] U.S. Code Cong. & Ad. News 961.

The Bill of Rights referred to by the Conference Report was the result of a substantial amount of congressional drafting and review. The Senate emphasized the need for institutional standards:

> Testimony before the committee demonstrated that standards in institutions for the developmentally disabled are urgently needed and that the Federal Government should play a major role in improving the care and services provided to developmentally disabled citizens. [Remarks of Senator Schweiker, 121 Cong. Rec. 16521 (1975).]

The Conference Committee report leaves no doubt that concrete rights were being established in Title II:

> The Conference substitute contains a compromise which enumerates Congressional findings respecting the rights of persons with developmental disabilities. These include findings that the developmentally disabled have a right to appropriate treatment, services and habilitation; that such treatment, services and habilitation should be designed to maximize the developmental potential of the person and be provided in the setting that is least restrictive to his personal liberty. . . . [H.R. Conf. Rep. No. 94-473, 41-42 (1975), [1975] U.S. Code Cong. & Ad. News 961.]

Senator Tom Stafford pointed out that "Title II was added to the bill to assist in the protection of the rights guaranteed under our Constitution for those individuals that will require institutionalization. . . ." 121 Cong. Rec. 16516 (1975). In Senator Schweiker's view, the Bill of Rights was needed to require "[h]umane care, treatment,

rehabilitation, and protection in residential facilities. . . ." *Id.* at 16522.

Having defined the need for federal action in the area of personal rights, Congress placed the "right to appropriate treatment, services, and habilitation for such disabilities" as the first priority. 42 U.S.C. § 6010(1). And, having eschewed enacting a detailed blueprint for the operation of institutions (Conference Report, *supra* at 41-42) Congress went to the simple and obvious alternative—a general right to "appropriate treatment." Senator Allan Cranston noted that the bill

> recognize[d] that the need for some long-term residential programs will remain. The bill specifically provides that where institutional programs are appropriate, adequate support should be planned for them so that necessary treatment and habilitation programs can be given residential patients to develop their full potential. 121 Cong. Rec. 16520 (1975).

Senator Williams, recalling committee testimony of such institutional abuses as "inappropriate and inhuman experimentation with residents, sterilizations and other operations performed for convenience of treatment, starvation and malnutrition, abuse and physical punishment, inadequate food and living conditions, and death," *Id.* at 16517, concluded that

> S. 462 provides a framework by which the constitutional rights of residents and other persons with developmental disabilities may be enforced. *Id.*

Clearly, the Act was conceived and enacted as a multifaceted device through which the scandal of the institutions was to be addressed. The "right to appropriate treatment" simply spells out the unifying theme that the failure to provide adequate treatment and care for the developmentally disabled can be tolerated no longer. Even the lengthy dissenting opinion of the Court of Appeals

declines to challenge this right to treatment or its enforceability, 612 F.2d at 117.

Congress accurately perceived, however, that the scandal was not limited to the way people were treated in the institutions. As unforgivable as the conditions in institutions were, there was a greater injustice:

> It must be recognized that the vast majority of developmentally disabled persons and the vast majority of persons now institutionalized should not be in these institutions at all. Efforts to assure proper treatment, education, and habilitation services in large institutions should not deflect attention from the fact that most of these institutions themselves are anachronisms, and that rapid steps should be taken to phase them out. S. Rep. 94-160 at 32-33.

And Congress realized that deinstitutionalization was an essential ingredient to appropriate treatment:

> Many of these institutions by their very nature, their size, their isolation, their impersonality, are unsuitable for treatment, education, and habilitation programs. *Id.* at 33.

Representative Andrew Young, when moving the bill out of the House Rules Committee, stated:

> Of particular significance in this bill is the emphasis on deinstitutionalization which would discontinue institutional maintenance and develop adequate community programs to serve this population. 121 Cong. Rec. at 9965 (1975).

Senator Cranston expressed his understanding of the purpose of the Act as follows:

> I believe one very clear basic goal has been enunciated in the legislation reported from committee. That is the need to move away from long-term institutionalization of individuals with developmental disabilities to the development of community-based pro-

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P.L. 94-103, § 111 (b) (23), 42 U.S.C. § 6063 (b) (23) (1976) (repealed) 28

Legislative History:

H.R. Rep. No. 94-58, 94th Cong., 1st Sess. (1975) 28

H.R. Rep. No. 94-473, 94th Cong., 1st Sess. (1975) 27

Hearings on S. 427 and S. 458 before the Subcom. on the Handicapped of the Sen. Comm. on Labor and Public Welfare, 93rd Cong., 1st Sess. (1973) 23

Hearings on H.R. 11511 before the Subcom. on Public Health and the Environment of the House Comm. on Interstate and Foreign Commerce, 93rd Cong., 2d Sess., pts. 1 and 2 (1974) 14, 23

Hearings on H.R. 2954, ect. before the House Sub-comm. on Public Health and the Environment of the House Comm. on Interstate and Foreign Commerce, 94th Cong., 1st Sess. (1975) 23

Hearings on S. 3378 before the Subcomm. on the Handicapped of the Sen. Comm. on Human Resources, 94th Cong., 1st Sess. (1975) 23

Hearings on S. 462 before the Subcomm. on the Handicapped of the Sen. Comm. on Human Resources, 94th Cong., 1st Sess. (1975) 23

Hearings on S. 2600 before the Subcomm. on the Handicapped of the Sen. Comm. on Human Resources, 95th Cong., 2d Sess. (1978) 23

American Federation of State, County and Municipal Employees, Patients for Sale (Preliminary Draft, May 27, 1980) 21

D. Bella and E. Zigler, *Mental Retardation,* in NEW PERSPECTIVES IN ABNORMAL PSYCHOLOGY (A. Kazdin, et al. eds., 1980) 4

Page

A. Baumeister *and* E. Butterfield, eds Residential Facilities for the Mentally Retarded (1970) 10, 13, 16, 30

M. Begab, ed., The Mentally Retarded and Society (1975) 2

M. Begab, *The Mentally Retarded and Society: and Issues,* in The Mentally Retarded and Society (1975) 13, 14, 16, 19

A. Birenbaum and M. Re, *Resettling Mentally ....Retarded Adults in the Community—Almost 4 Years Later,* 83 American Journal of Mental Deficiency (1970) 11

C. Blue, *Education of the Mentally Retarded in Residential Settings,* in Residential Facilities for the Mentally Retarded (A. Baumeister and E. Butterfield, eds., 1970) 16, 30

Bowman, Neglect of the Profoundly Retarded, 11 PCMR Message 2 (1968) 5

Bowning, *Normalization at What Price?,* 15 Mental Retardation 24 (December, 1977) 10, 15

R. Bruininks, et al., National Survey of Community Residential Facilities (Developmental Disabilities Project on Residential Services and Community Adjustment, University of Minnesota, Project Report No. 5, 1979) 1, 19, 20

E. Butler and A. Bajaanes, Deinstitutionalization, Environmental Normalization, and Client Normalization, and Client Normalization (paper presented at the American Association on Mental Deficiency and National Association of Private Residential Facilities for the Mentally Retarded San Francisco, California, May 14, 1980) 12

E. Butler and A. Bjaanes, *A Typology of Community*

Page

Care Facilities and Differential Normalization Outcomes, in RESERCH TO PRACTICE IN MENTAL RETARDATION (P. Miller ed., 1977) 8, 11

E. Butterfield and E. Zigler, *The Influence of Differing Institutional Social Climates on the Effectiveness of Social Reinforcement in the Mentally Retarded,* 70 AMERICAN JOURNAL OF MENTAL DEFICIENCY DR (1965) 13

W. Cochran, P. Scran, and G. Varano, *The Relocation Syndrome in Mentally Retarded Individuals,* 15 MENTAL RETARDATION 10) (April, 1977) 15

C. CLELAND, THE PROFOUNDLY MENTALLY AVTGTQ 5, 17

C. CLELAND, ed., RESEARCH WITH THE PROFOUNDLY R59(8454, vol. I (1975) 17

J. Clements, *Medical Services in Institutions for the Mantally Retarded,* in RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED (A. Baumeister and E. Butterfield, eds., 1970) 16

J. Clements, *Planning a Residential Facility for the Mentally Retarded,* in RESIDENTAL FACILITIES FOR THE MENTALLY RETARDED (A. Baumeister and E. Butterfield eds. 1970) 30

Comptroller General of the United tSates, Returning the Mentally Disabled to the Community(Report to the Congress, 1977) 2, 10, 21

J. Conroy, *Trends in Deinstitutionalization of the Mentally Retarded,* 15 MENTAL RETARDATION 46 (August,, 1977) 18

Detroit Research Institute, The Illusion of Deinstitutionalization (University of Denver, October 1978) 21

R. EDGERTON, THE CLOAK OF COMPETENCE (1967) 15

R. Edgerton, *Issues Relating to the Quality of Life Among Retarded Persons,* in THE MENTALLY RETARDED AND SOCIETY (M. Begab ed. 1975) 2, 8, 20

M. Egg-Benes, *Integration of the Mentally Retarded in Society,* in RESEARCH TO PRACTICE IN MENTAL RETARDATION, vol. 1. (P. Mittler ed. 1977). 8

R. Eyman and T. Call, *Maladoptive Behavior and Community Placement of Mentally Retarded Persons,* 82 AMERICAN JOURNAL OF MENTAL DEFICIENCY 137 (1977) 17

E. GOLLAY, et al., COMING BACK (1978) 18

H. Gunzberg, Editorial in THE BRITISH JOURNAL OF MENTAL SUBNORMALITY, Vol. XXVIII, Part 2 (December 1972) 11, 15

H. Haywood, ed., SOCIAL-CULTURAL ASPECTS OF MENTAL RETARDATION (1970) 9

R. ISAACSON, MEETING THE NEEDS OF THE RETARDED (1977) 5, 9, 10, 14, 15, 18

A. KAZDIN, et al., eds., NEW PERSPECTIVES IN ABNORMAL PSYCHOLOGY (1980) 4

R. KING, N. RAYNES and J. TIZARD, PATTERNS OF RESIDENTIAL CARE (1971) 13

K. Kreger, *Compensatory Environment Programming for the Severely Retarded Behaviorally Disturbed,* 10 MENTAL RETARDATION 29 (August, 1971) 12, 30

Longitudinal Study of the Court-Ordered Deinstitutionalization of Pennhurst: Historical Overview I (Report to U.S. Department of Health and Human Services submitted by Government Studies and Systems, Philadelphia, Pennsylvania, April 7, 1980). 17, 19, 20

T. Mayeda, et al., Current Costs for Care of Developmentally Disabled Clients in Community Based and Institutional Settings (U.C.L.A. Neuropsyychistic Institute Research Group, Pacific State Hospital, Pomona, California, June 1977) 17

R. McCarver and E. Craig, *Placement of the Retard-*

ed in the Community: Prognosis and Outcome, 7 INTERNATIONAL REVIEW OF RESEARCH IN MENTAL RETARDATION 145 (1974). 18

Mesibov, *Alternatives to the Principle of Normalization,* 14 MENTAL RETARDATION 31 (October, 1976). 10, 14

C. Miller, *Deinstitutionalization and Mortality Trends for the Profoundly Retarded,* in RESEARCH WITH THE PROFOUNDLY RETARDED, Vol. I (C. Cleland, ed., 1975) 17

P. MITTLER, ed., RESEARCH TO PRACTICE IN MENTAL RETARDATION, Vol. 1 (1977) 8, 13

O'Connor, Home is a Good Place (Monograph of the American Association of Mental Deficiency, No. 2, 1976) 20

C. Overboe and Y. Wang, Behavioral and Physical Characteristics of Developmentally Disabled Individuals (University of Wisconsin-Madison, Waisman Center, 1979) 4, 5

Parnicky, *Pathways Toward Independence for Institutionalized Mildly Retarded Adults,* in RESEARCH TO PRACTICE IN MENTAL RETARDATION (P. Mittler ed., 1977) 13

P. Roos, *Evolutionary Changes of the Residential Facility,* in RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED (A. Baumeister and E. Butterfield eds., 1970) 10, 13, 30

P. Roos, *The Law and Mentally Retarded People: An Uncertain Future,* 31 STAN. L. REV. 613 (1979) 7, 10

D. Primrose, Asylum, in RESEARCH TO PRACTICE IN MENTAL RETARDATION (P. Mittler ed. 1977) 15

M. ROSEN, et al., HABILITATION OF THE HANDICAPPED (1977) 10, 13, 14, 30

R. Scheerenberger, Community Programs and Services

(ational Association of Superintendents of Public Residential Facilities for the Mentally Retarded, 1980) 17

R. Scheerenberger, Public Residential Services for the Mentally Retarded (National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, 1979) 4, 18

Schwartz, *Normalization and Idealism,* 15 MENTAL RETARDATION 39 (December, 1977) 10, 15

A. SCULL, DECARCERATION (1977) 21

Skarnoulis, *Least Restrictive Alternatives in Residential Services,* JOURNAL OF THE AMERICAN ASSOCIATION FOR THE EDUCATION OF THE SEVERELY HANDICAPPED, vol. 1, issue 3 (January, 1976) 18

J. Throne, Is Deinstitutionalization Dictated by the Least Restrictiveness Principle? (paper presented at the Meeting of the American Association on Mental Deficiency, Miami Beach, Florida, May-June, 1979) 9

T. Throne, *Deinstitutionalization: Too Wide a Swath,* 18 MENTAL RETARDATION 171 (August, 1979) 13

J. Throne, *Normalization Through the Normalization Principle: Right Ends, Wrong Means,* 13 MENTAL RETARDATION 23 (October, 1975) 14

J. Tizard, *The Role of Social Institutions in the Causation, Prevention and Alleviation of Mental Retardation,* in SOCIAL-CULTURAL ASPECTS OF MENTAL RETARDATION (H. Haywood, ed., 1970)) 9, 18

BRIEF FOR CONGRESS OF ADVOCATES FOR THE RETARDED, INC., et al., AMICI CURIAE

INTEREST OF THE AMICI

As more fully explained in the motion for leave to file this brief (hereinafter "Motion"), *amici* are organizations of parents, relatives and other advocates of the interests of retarded people who believe that the decision below, by establishing a presumption in favor of the court-ordered removal of retarded individuals from institutions, will produce results contrary both to Congress' intent and to the best interests of the retarded. *Amici* therefore support the position of those petitioners who contend that this presumption should be set aside.

INTRODUCTION AND SUMMARY OF ARGUMENT

The court below has held that § 6010(2) of the Developmentally Disabled Assistance and Bill of Rights Act (hereinafter "the Act") empowers the federal courts to relocate retarded persons to the "least restrictive environment" in which they can be treated. 612 F.2d at 103-107. And, the court has further held that in exercising that power, "the court or the Master should engage a presumption in favor of placing individuals in CLAs [community living arrangements]" rather than in institutions, with institutionalization permitted only in an "extreme situation." Id. at 115-116. As explained in the Motion, p. iii, in many cases retarded persons, their parents and their professional advisors do not favor transfers from institutions to CLAs—i.e., nursing homes, foster homes, "board and care" facilities, or private homes or apartments whose proprietors have contracted with the state to supervise one or more retarded persons.[1] But the ruling below would result in such transfers nonetheless.

[1] For discussions of the types of CLAs, see R. Bruininks, F. Hauber and M. Kudla, National Survey of Community Residential Facilities 11-12, 56, 60 (Developmental Disabilities Project on Residential Services and Community Adjustment, University of

In this brief, *amici* do not address the threshold question whether the statutory finding that retarded persons should receive treatment in the "least restrictive environment" is judicially enforceable. Rather, this brief addresses an important subsidiary issue which is before the Court: assuming *arguendo* the finding is judicially enforceable, did Congress intend that it should be implemented with a presumption in favor of CLAs?

An understanding of the specialized world about which Congress was legislating "give[s] life to the dead words of a statute dealing with it" (*United States* v. *Maher*, 307 U.S. 148, 166). The court below misunderstood the nature of the population of mentally retarded persons who reside in institutions, and it misunderstood as well the relative capacities of institutions and CLAs to provide treatment to that specialized population. Its construction of the statute consequently was premised upon a series of misconceptions. We show this in Part I.

In Part II, we show from the language, structure and history of the Act, examined free of those misconceptions, that Congress did not mandate a presumption in favor of deinstitutionalization. The provision upon which the court below relied (42 U.S.C. § 6010(2)), cannot be construed to establish such a presumption; and the provision which designates the programs for which federal funds are to be utilized by the States (42 U.S.C. § 6063) shows that the presumption is in fact contrary to congressional intent.

Minnesota, Project Report No. 5, 1979); R. Edgerton, *Issues Relating to the Quality of Life Among Retarded Persons*, in THE MENTALLY RETARDED AND SOCIETY 127, 129-130 (M. Begab ed. 1975); Comptroller General of the United States, Returning the Mentally Disabled to the Community 8-25 (Report to the Congress, 1977).

The Act does not define the term "community living arrangements." Neither did the court of appeals. As the dissent noted, one of plaintiffs' experts testified at trial that rented rooms at Holiday Inns are "one type of community-living arrangement." (612 F.2d at 128, n. 5).

ARGUMENT

I. THE COURT OF APPEALS TOTALLY MISUNDERSTOOD THE NATURE OF THE DISABILITIES AND NEEDS OF THOSE RETARDED PEOPLE WHO PRESENTLY RESIDE IN INSTITUTIONS.

A. The Degree of the Disabilities Suffered by the Mentally Retarded Residents of Public Institutions Is Far More Severe Than the Court Below Believed.

The root of the lower court's error was its failure to appreciate the nature and extent of the disabilities suffered by the mentally retarded residents of institutions such as Pennhurst. Although acknowledging that "some" Pennhurst residents suffer from physical as well as mental disabilities, and that "some" cannot care for themselves, the court asserted that "[w]hile the mentally retarded do suffer educational difficulties, the level of their functioning can be improved by individualized training." 612 F.2d at 92. The court believed there is broad potential for "remediation of the delayed learning process" in mentally retarded persons, if proper treatment is provided "under normalization principles." *Id.* at 93. The district court engaged in even more heroic optimism, explaining that "[m]ental retardation is primarily an educational problem," that "with proper habilitation, the level of functioning of every retarded person may be improved," and that "[a]n individual may be functioning at a retarded level due to lack of education and/or training, and once supplied with that education and/or training, may be removed from the ranks of the retarded." Pet. App. 103a and n.5. Fortified by that rosy view, the district court agreed with "[a]ll the parties to this litigation . . . that given appropriate community facilities, all the residents at Pennhurst, even the most profoundly retarded with multiple handicaps, should be living in the community." *Id.* at 131a.[2]

[2] As explained in the Motion, pp. iv-v, because of their particular interests "the parties to this litigation" did not present a balanced view of these matters, and the Parents-Staff Association which sought to correct that imbalance was denied intervention, with the result that the trial testimony was one-sided.

The lower courts' optimism may be justified for most retarded persons—i.e., for those with relatively little retardation. But most of those people live at home with their families, or already live in CLAs.[3] Only a very small percentage of retarded persons live in institutions, but they are, by and large, the most seriously retarded, with prospects altogether different from those whose retardation is less acute.

The great majority of retarded people—some 89%—are classified as only "mildly" retarded. Of the remainder, 6% are "moderately" retarded, with an IQ between 36 and 51; 3.5% are "severely" retarded, with an IQ between 20 and 35; and 1.5% are "profoundly" retarded, with an IQ below 20.[4] But while the severely and profoundly retarded constitute only 5% of the retarded population, at Pennhurst, 74% of the residents are either severely or profoundly retarded. Pet. App. 112a. And that is typical; nationwide, 44% of the residents of public institutions for the retarded are profoundly retarded, and 30% severely retarded.[5] Hence, generalizations about "the mentally retarded"—such as the district court's assertion that "[e]ighty-five percent of the mentally retarded can be employed"[6]—are inapplicable to the residents of public institutions, a specialized population of the most difficult cases.

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[3] The retarded population numbers in the millions. See C. Overboe and Y. Wang, Behavioral and Physical Characteristics of Developmentally Disabled Individuals 9 (University of Wisconsin—Madison, Waisman Center, 1979). Of these, only some 140,000 are in institutions. R. Scheerenberger, Public Residential Services for the Mentally Retarded 3-5 (National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, 1979).

[4] See Pet. App. 104a; C. Overboe and Y. Wang, *supra* at 14. And for a general treatment of the nature of mental retardation, see D. Balla and E. Zigler, *Mental Retardation*, in NEW PERSPECTIVES IN ABNORMAL PSYCHOLOGY 396-416 (A. Kazdin, et al., eds., 1980).

[5] C. Overboe and Y. Wang, *supra* at 45.

[6] Pet. App. 133a.

Profoundly retarded individuals generally cannot aspire to a mental age of more than 2 to 2½ years. C. CLELAND, THE PROFOUNDLY MENTALLY RETARDED 3 (1979). "In profound retardation, there will rarely be any intelligible speech even at adulthood except for a few individuals who may say 'mama' or 'da-da.' . . . Often, sensory defects, skeletal anomalies, or other disabilities co-exist in profoundly retarded persons. . . . Therefore, total life support is essential to their survival, and up to 40% of the profoundly retarded are either bedfast or semi-ambulatory. . . ." *Id.* at 3. The average age at death is under 40. *Id.* at 8.

Some 80% of profoundly retarded persons cannot control their urination or bowel movements (*id.* at 58); highly aggressive behavior is very common (*id.* at 23-25); and such habits as pica (eating of dirt and other objects) and coprophagy (eating of feces) are "not infrequently observed." *Id.* at 52. The helplessness of these individuals has been poignantly captured by one expert in these terms:

> Left to his own resources, even in a grocery store, the profoundly retarded person dies within a matter of days of starvation if he does not meet with accidental death before that.

Bowman, Neglect of the Profoundly Retarded, letter reprinted in 11 PCMR Message 2 (1968).

The picture is not much brighter with respect to the "severely" retarded, who have a mental age generally below 3½ to 4 years, and only the bare rudiments of speech. CLELAND, *supra* at 3. And these are permanent, incurable disabilities, generally resulting from organic brain damage. See, e.g., R. ISAACSON, MEETING THE NEEDS OF THE RETARDED 79 (1977).

Moreover, in general between 65 and 100% of the residents of public institutions for the retarded have at least one major handicap in addition to their retardation, and over a third have two or more such handicaps;[7] 25% cannot

[7] C. Overboe and Y. Wang, *supra* at 42, 46, 67-68.

walk;[8] 24% have impaired use of their hands or arms;[9] 32.5% have epilepsy;[10] 9.7% are blind or deaf.[11]

The court of appeals apparently was unaware of these facts when it described retardation as merely an "educational" difficulty. And as we now show, the court's belief that virtually all the retarded people in institutions could be "normalized" in "less restrictive" settings—which underpinned its adoption of the presumption in favor of deinstitutionalization—is similarly divorced from reality.

B. The Reality of Mental Retardation Is Inconsistent with a Presumption in Favor of Deinstitutionalization.

1. It Cannot Be Assumed That For a Particular Retarded Individual, a CLA Will be "Less Restrictive" or "More Normalizing" than an Institution.

In construing the Act to create a presumption in favor of transferring retarded people from institutions to CLAs, the court of appeals emphasized the district court's "finding" that CIAs are better attuned to "normalization principals," because they are "closer to and more reflective of the normal society" than are institutions, which the court characterized as necessarily "separate" and "isolated." 612 F.2d at 93. The court also assumed that CLAs are intrinsically "less restrictive" of a person's liberty than are institutions. *Id.* at 114. These simplistic assumptions are misconceived.

a). **"Restrictiveness."** For those retarded people who could conceivably be transferred to a CLA,[12] the mere fact that a particular institution is not located "in the commu-

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[8] *Id* at 43.

[9] *Ibid.*

[10] *Id.* at 46.

[11] *Ibid.*

[12] As we show in Part B-2, *infra*, for many retarded people transfer to a CLA would be disastrous because a CLA could not provide the comprehensive care they need.

nity," or that it is "large," does not mean that the institution is necessarily more restrictive of personal liberty than a CLA would be. In the first place, the conditions which afford meaningful freedom for retarded people are different than for normal people:

> [H]ow do we determine "restrictiveness"? It may be naive to assume that the most "normative" setting is necessarily the least restrictive for everyone. What feels restrictive to one person may feel unconstraining to another. A wheelchair is a restriction to an ambulatory person, but it provides increased freedom to a paraplegic. The problem is especially complicated for persons suffering sensory or cognitive impairment. A setting which provides freedom to a nonhandicapped person may be more restrictive to a handicapped person than a specially designed prosthetic environment. And the problem is more complicated still when the least restrictive alternative test is applied to the larger social environment in which a retarded person lives as opposed to facilities designed for specific programs. A small group home nestled in a hostile neighborhood, even if honorifically labeled as "community care," or a place "in the community," may be considerably more restrictive to its residents than a small village-type facility in which retarded residents are full participants in their own "community," even if some might call that community an "institution." The ultimate complexity of the least-restrictive alternative analysis, however, may be that restrictiveness and freedom are experiences of individuals, and that categorical determinations of these matters will always be clumsy.

Roos, *The Law and Mentally Retarded People: An Uncertain Future*, 31 STAN.L.REV. 613, 622 (1979).

The court's assumption that institutions are inherently more "restrictive" than CLAs overlooks not only the need to define what is "restrictive" for the unique population involved, but also the fact that there are enormous differences in degree of restrictiveness among individual institutions, and among individuals CLAs:

> An institution of over a thousand residents can be an impersonal, overcrowded, inhuman place, but it can also

> be a happy community with the pulsing life of a prosperious village, where everybody can find what he needs. On the other hand, a small group home for six retarded persons can be a pleasant family-like place, but it can also be a ghetto, where handicapped persons live out their lives without the necessary special services and without the sympathy of their neighbors.

M. Egg-Benes, *Integration of the Mentally Retarded in Society*, in RESEARCH TO PRACTICE IN MENTAL RETARDATION, vol. 1, (hereafter RESEARCH TO PRACTICE) at 351-352 (P. Mittler ed. 1977).

Thus, contrary to the court's view of CLAs as citadels of freedom, a thorough study of CLAs in Southern California found that among the "board and care" facilities—one of the most prevalent types of CLAs—"[m]ost . . . are closed, ghetto-like places, whose residents are walled off from any access to community life." R. Edgerton, *Issues Relating to the Quality of Life Among Mentally Retarded Persons*, in THE MENTALLY RETARDED AND SOCIETY 130 (M. Begab ed. 1975). The study concluded that "[f]or most mentally retarded people in this system . . ., the little institutions where they now reside appear to be no better than the large ones from which they came, and some are manifestly worse." *Id.* at 131. Other studies have confirmed that many CLAs are simply "creating socially isolated total institutions within the community." E. Butler and A. Bjaanes, *A Typology of Community Care Facilities and Differential Normalization Outcomes*, in RESEARCH TO PRACTICE, *supra*, at 342.

Just as there is no guarantee that a CLA will provide "freedom," neither does it follow that an institution will impose unnecessary restraints. As stated by Dr. John Throne of the University of Kansas and the Lakemary Center for Exceptional Children:

> [T]here is little doubt that all, or virtually all institutions can meet many or most if not all of the myriad and diverse needs of the retarded . . . without undue or inappropriate restrictions on their freedoms. This principle has been demonstrated in practice time and time again in a variety of institutions provided with the necessary organizational, administrative, and man-

> agerial structures. Those denying in court the principle or the practice appear to be unaware of the size and significance of the literature on the subject . . . .
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> * * *
>
> [T]here are simply no preestablished grounds . . . for assuming that one category of institution, from "large" through family abode to dwelling for one . . . is inherently more or inherently less restrictive than any other . . . .
>
> Depending solely on the organizational, administrative, and managerial policies and procedures adopted, doors in any institution can be locked, closed or open. Comings and goings can be stopped, intermittent or free. Institutions can be throttling, regulating or permissive. They can defeat, bore, or enrich. They can kill. They can stultify. They can enliven.[13]

b). **"Normalization."** The considerations just discussed also reveal the fallacies in the court's assumption that CLAs inherently provide a more "normal" life than institutions, and thereby serve to "normalize" their residents.[14]

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[13] J. Throne, Is Deinstitutionalization Dictated by the Least Restrictiveness Principle? (paper presented at the Meeting of the American Association on Mental Deficiency, Miami Beach, Florida, May-June, 1979). See also R. ISAACSON, *supra* at 164. And see note 21 *infra*. Indeed, because institutions can offer expansive grounds with many opportunities for recreation and other activities, they offer a wealth of possibilities for a rich and active life, without the inhibiting dangers which the community poses to many of the retarded. See, e.g., J. Tizard, *The Role of Social Institutions in the Causation, Prevention and Alleviation of Mental Retardation*, in SOCIAL-CULTURAL ASPECTS OF MENTAL RETARDATION 281-321 (H. Haywood, ed. 1970) ("one of [the] attractions of large institutions, as communities in which to live, lies in the fact that they commonly have farms, gardens, and playgrounds attached to them").

[14] The lower court's emphasis on "normalization" raises the threshold problem that neither Congress nor the profession has defined what the objectives of an habilitation program should be. For mental retardation, unlike physical diseases and most mental illnesses, there is no such thing as a "cure," and conceptions of the appropriate purposes of habilitation are necessarily complex. One

For many retarded people, removal from an institution in no way marks the beginning of a "normal" life or of meaningful community contact. For example, some 26 percent of the retarded who have been released from public institutions were moved to nursing homes,[15] often as a di-

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possible objective, which the lower courts erroneously assumed to be the only valid objective, is "normalization"—that is, an effort to equip retarded individuals to live as "normal" a life as possible. "Under this view, the professional helping the retarded is in effect a 'human manager' inducing in the retarded person the most socially acceptable behavior possible." Roos, *supra*, 31 STAN.L. REV. at 616. But the induction of socially acceptable behavior is not considered the only proper objective of habilitation programs. Other objectives include the maximization of intellectual potential, or of independence and self-sufficiency, or of economic productivity, or simply of happiness and contentment. *Id.* at 616-617. See also M. ROSEN, et al., HABILITATION OF THE HANDICAPPED 115-125 (1977). Indeed, if pursued without consideration of such other goals, "normalization" would lead to no more than a "pretense of equality" (Schwartz, *Normalization and Idealism*, 15 MENTAL RETARDATION 39 (December 1977), at the expense of "more enduring human goals. . . ." Mesibov, *Alternatives to the Principle of Normalization*, 14 MENTAL RETARDATION 31 (October 1976). See also R. ISAACSON, *supra* at 85-86, 181; Browning, *Normalization at What Price?* 15 MENTAL RETARDATION 24 (December 1977).

It follows that the choice of the objectives for an habilitation program is "basically dependent on ethical values. . . . These goals may be mutually incompatible, and each would very likely lead to markedly different programs." P. Roos, *Evolutionary Changes of the Residential Facility*, in RESIDENTIAL FACILITIES FOR THE MENTALLY RETARDED (hereinafter RESIDENTIAL FACILITIES) 29, 55 (A. Baumeister and E. Butterfield eds., 1970). Thus, any attempt to prescribe the "best" type of habilitation program necessarily involves making choices of social policy which there is nothing to suggest Congress made in adopting the Act—choices which the court below made according to its own lights.

[15] Comptroller General, Returning the Mentally Disabled to the Community, *supra* note 1, at 11 (1977). Indeed, the number of retarded people in nursing homes increased by 48 percent between the years 1969 and 1974. *Ibid.*

rect result of litigation directed against public institutions.[16] In the typical nursing home, life for the retarded consists "[f]or the most part . . . [of] just sitting, watching television, or lying on their beds." [17]

Even in smaller CLAs, the residents generally have little contact with the community, and are not exposed to activities which might have a "normalizing" effect. See, e.g., E. Butler and A. Bjannes, *supra* at 342, 345-346;[18] R. Edgerton, *supra;* H. Gunzburg, *Editorial,* in THE BRITISH JOURNAL OF MENTAL SUBNORMALITY, vol. XXVIII, Part 2, at 63-65 (December 1972); A Birenbaum and M. Re, *Resettling Mentally Retarded Adults in the Community—Almost 4 Years Later,* 83 AMERICAN JOURNAL OF MENTAL DEFICIENCY 323, 327-329 (1970).[19]

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[16] *Id* at 13. And see p. .... *infra.*

[17] *Id.* at 14.

[18] "Our data show that small facilities rarely use outside opportunities and that wide interaction with external settings is critically absent. . . ." *Id.* at 342.

[19] Because of the special needs of the retarded, merely placing a retarded individual in a superficially normal environment is of little, if any, significance. Any meaningful efforts at "normalization" must depend on the provision of specialized services which enable a retarded person to become actively involved, to the extent possible, in normal activities. As stated by Butler and Bjannes, *supra* at 345:

> In order to provide a normalizing environment, community care facilities must provide an environment which is actively enriched both with internal programs and external contact and exchange.
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> * * * *
>
> While this is obvious in large facilities, it is *particularly critical in small care facilities,* which, by virtue of size, must include activities and external interaction to approximate a normal environment. Isolation in small care facilities results in a social setting populated only by developmentally disabled persons, thus restricting activities, the number of role models, and experiences necessary for normalization to occur (emphasis added).

Conversely, there is nothing about institutions which makes them inherently incompatible with the concept of "normal" life for the retarded. As stated by Egg-Benes, *supra*, if properly developed and managed an institution can be "a happy community with the pulsing life of a prosperous village, where everybody can find what he needs." Steps taken by one institution, serving severely and profoundly retarded people with major behavioral problems, to "provide a livable and humane situation in which these residents could live comfortably and productively" were described in K. Kreger, *Compensatory Environment Programming for the Severely Retarded Behaviorally Disturbed*, 10 MENTAL RETARDATION 29, 30 (August, 1971):

> Among the activities that were introduced were such things as developing a garden plot, raising plants in the building, playing shuffleboard and pool, setting up large rolls of paper across dayroom walls for coloring and art work, going for walks in small groups, going fishing at a nearby stream, riding bicycles, repairing furniture, polishing stones, and even such things as taking groups of residents out of doors late at night to observe the sky and to see what the world looks like to normal persons who are free and able anytime to walk out of doors and see the sky and the stars. Likewise, we have introduced boy-girl activities, dances, parties, and boys and girls going on walks together accompanied by staff.

In short, institutions can encourage and facilitate participation by retarded people in many facets of "normal life." Many institutions do; the rest could.[20] For what

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But as Butler and Bjannes found, a great many CLAs—particularly the smaller ones—do *not* provide these necessary services. *Id.* at 342-346. Indeed, Butler and Bjannes have found hat institutions are generally superior to CLAs in providing the kinds of services which enable retarded people to participate in activities of normal life. See E. Butler and A. Bjannes, Deinstitutionalization, Environmental Normalization, and Client Normalization 6-11 (paper presented at the American Association on Mental Deficiency and National Association of Private Residential Facilities for the Mentally Retarded, San Francisco, California, May 14, 1980).

[20] See, e.g. M. ROSEN, et al., *An Institution Transformed*, in

matters is not the location of a facility, but how it is managed, and what policies its staff implements.[21]

HABILITATION OF THE HANDICAPPED *supra*, at 61-74; E. Butterfield and E. Zigler, *The Influence of Differing Institutional Social Climates on the Effectiveness of Social Reinforcement in the Mentally Retarded*, in 70 AMERICAN JOURNAL OF MENTAL DEFICIENCY 48-49 (1965). In this regard it should be emphasized that the abusive conditions which the court below found to have prevailed in the past at Pennhurst represent an extreme situation which need not—and ought not—exist at any institution. It is perhaps natural that in the wake of well-publicized revelations concerning "the indignities of back ward life" in the worst institutions, to observers who are not fully informed "all institutions have been tainted and community-based services have taken on a saintly glow." M. Begab, *The Mentally Retarded and Society: Trends and Issues*, in THE MENTALLY RETARDED AND SOCIETY 18 (M. Begab ed 1975). But "[b]oth notions distort the facts." *Ibid.* Thus:

> Simple black and white generalizations cannot be drawn. Institutions are complex social environments differing in size, degree of freedom, or regimentation afforded, in quality of supervision and leadership (which itself may vary in degree of authoritarian control, punitiveness, benevolence), in physical structure, population, and characteristics of residents, and in degree of community involvement, medical versus educational or habilitation orientation, and numerous other variables.

Rosen, *supra* at 109.

[21] See, e.g., J. Throne, *Deinstitutionalization: Too Wide a Swath*, 18 MENTAL RETARDATION 171 (August, 1979); M. Begab, *supra* at 17-21; R. KING, N. RAINES AND J. TAZARD, PATTERNS OF RESIDENTIAL CARE 114-115 (1971). Institutions in no way reject the concept that those retarded people who could potentially benefit from life in the community should be enabled to do so; to the contrary, to an ever-increasing extent one of the primary objectives of institutions is to prepare residents for community life insofar as possible. And institutions can offer programs uniquely suited to that end, such as sheltered workshops, half-way houses, "quarter-way houses" (in which retarded people live in the institution but work in the community) and home-like cottages on institution grounds. See, e.g., Rosen, *supra* note 14, at 61-74; P. Roos, *Evolutionary Changes of the Residential Facility*, *supra* note 14, at 35-36; J. Parnicky, *Pathways Toward Independence for Institutionalized, Moderately Retarded Adults*, in RESEARCH TO PRACTICE, *supra* at

Of course, in many respects the life of a retarded person in an institution—or in a CLA—can never be fully normal: "[a]lthough there can be no question that retarded people can be treated more normally than in the past, at some point we must all come to grips with the fact that they are in fact different because they lack a most important asset for success in our complex, industrialized society." Mesibov, *Alternatives to the Principle of Normalization, supra* note 14, at 31. If they are to develop some of the skills and capacities of normal people which they lack, retarded individuals cannot simply be treated as if they were already normal. See, e.g., J. Throne, *Normalization Through the Normalization Principle: Right Ends, Wrong Means*, 13 MENTAL RETARDATION 23 (October, 1975); R. ISAACSON, *supra* at 16. For this reason, to the extent that a retarded person living in an institution resides in a "sheltered environment" and has more contact with other retarded people than with "the community," it is far from clear that this situation is undesirable.

295-304. Indeed, "to have a good community program you must have a good institutional program . . . ." Testimony of Dr. David Rosen, then President of the American Association on Mental Deficiency, in *Hearings on H.R. 11511, etc. before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce* 1046 (93 Cong., 2d Sess. 1974). As the foregoing indicates, the court of appeals was wrong in its belief that institutions necessarily bring about "the imposition or facilitation of increased retardation." 612 F.2d at 93. In general, studies of institutions have found a positive impact on the development of self-confidence, self-direction, and motivation. See ROSEN, *supra* at 108. In addition, studies of several institutions have found general increases in IQs, although studies of some other institutions have found general decreases. See M. Begab, *supra*, at 19-20; D. Primrose, *Asylum*, in RESEARCH TO PRACTICE, *supra* at 264-265. The conclusion which is supported by the data is that institutionalization can have either a beneficial or an adverse impact on personality development and intelligence, depending on the programs of the particular institution and the needs of the particular resident. See, e.g., J. Throne, *Deinstitutionalization: Too Wide a Swath, supra*, at 174.

For example, "[o]ne advantage of a large institution is the ability to form peer groups for the patients, groups where they are no longer the least efficient member and where they are not ridiculed because of their inadequacy." D. Primrose, *Asylum, supra* note 21, at 265. See also P. Browning, *Normalization at What Price?, supra* note 14. Forcing retarded individuals to leave their peers and enter the "community" often leads to "enormous loss, isolation and self-hatred." Schwartz, *Normalization and Idealism, supra* note 14, at 39.[22] "We have failed to examine the capacity of retarded persons to adapt to the pressures of this highly industrialized and competitive society, and have in essence forced upon them defensive maneuvers that minimize emotional growth and perception of reality. . . . The personal life of the retarded person is . . . reduced to more and more frustration and isolation." *Id.* at 38-39. And see generally EDGERTON, THE CLOAK OF COMPETENCE (1967); R. ISAACSON, *supra;* H. Gunzburg, *supra,* at 64.

2. For Many Retarded People, Only an Institution Can Provide Adequate Services and Programs.

What has been said to this point is sufficient to show the incorrectness of the court's belief that CLAs are to be favored as inherently more "normal" and less "restrictive" than institutions. But that is only one dimension of the court's error. Another, equally important, lies in the fact that for a great many of the retarded—and particularly the most severe cases, who comprise such a large percentage of the population of public institutions—CLAs cannot provide the comprehensive care and programs which they need.

"[T]he marked heterogeneity of the retarded population clearly indicates that what is possible for some is not so

[22] Even apart from the loss of peers, the disruption of a retarded individual's environment which is caused by a move from an institution to a CLA in itself tends to produce severe emotional problems. See W. Cochran, P. Sran, and G. Varano, *The Relocation Syndrome in Mentally Retarded Individuals,* 15 MENTAL RETARDATION 10 (April 1977).

for others," and this "militates against any single pattern or program [of care]." Begab, *supra* note 20, at 17, 18. As has been noted (pp. 3-6 *supra*), many retarded people—particularly those with the most difficult problems, who comprise the bulk of the population of public institutions—require total care and a vast array of services. Such comprehensive services are "logistically difficult to provide in scattered facilities serving individual or small groups of [the retarded]," but can readily be made available in institutions. Id. at 18.[23]

A recent survey found that in all three areas of services reviewed—educational services, medical services, and adult programming and behavior management programs—CLAs in every region of the country are providing inadequate ser-

[23] Obviously, a CLA serving a handful of residents cannot provide the necessary services itself. Nor is it safe to rely on services in the community, because retarded people require the care of specialists. This is true not only as to those types of services which are most directly associated with the retarded (such as unique educational programs, therapy, etc.) but as to virtually *all* the services a retarded person needs. For example, even for what would ordinarily be a routine illness, a general practioner in the community is likely to experience great difficulty in attempting to treat a profoundly retarded adult with multiple disabilities who cannot describe his sypmtoms, whose behavior may be erratic, and whose disabilities are likely to be unfamiliar to the doctor. See J. Clements, *Medical Services in Institutions for the Mentally Retarded*, in RESIDENTIAL FACILITIES, *supra* at 317-318. And even were it possible to provide the necessary specialized services at sites in the community, it would be an extremely difficult matter to assure access by the residents of each of the separate CLAs to the services as needed. In contrast, an institution can provide virtually all the necessary services on its premises, and can therefore make them readily accessible to the residents. See generally RESIDENTIAL FACILITIES, supra. What is more, this accessibility makes it possible to establish programs which could not readily be established outside the institution, by "capitaliz[ing] on the inherent advantages of the institutional structure. . . ." C. Blue, *Education of the Mentally Retarded in Residential Settings*, in RESIDENTIAL FACILITIES, *supra* at 289. See also *id.* at 303-305.

vices for the severely and profoundly retarded. R. Scheerenberger, Community Programs and Services 8 (National Association of Superintendents of Public Residential Facilities for the Mentally Retarded, 1980).[24]

To apply a presumption in favor of CLAs is thus rash. "Knowing the fragility of the [profoundly mentally retarded] and the hazards of relocating them . . ., deinstitutionalization zealots could be consigning them to an early death." C. Cleland, THE PROFOUNDLY MENTALLY RETARDED, *supra*, at 129.[25]

In addition to the problem of services, the behavior maladjustments of many retarded people can preclude successful placement in a CLA. See, e.g., R. Eyman and T. Call, *Maladaptive Behavior and Community Placement of Mentally Retarded Persons*, 82 AMERICAN JOURNAL OF MENTAL DEFICIENCY 137, 143 (1977).

Factors such as these no doubt explain why, in Pennsylvania, the severely or profoundly retarded constitute only 14% of the residents of CLAs, but 72% of the residents of institutions.[26] Placement in the community is simply un-

[24] Similarly, "[w]hile the quality of alternative living facilities was rated rather adequate for the more mildly affected, it was considered less than adequate for the severely and profoundly retarded." *Id.* at 30. The general failure of CLAs to provide adequate services explains why CLAs are often thought to be a less costly means of habilitation, per resident, than institutions. The most thorough study of this question concludes that if CLAs provided the same quality of services as are available in institutions, they would *not* be less costly than institutions. T. Mayeda, et al., Current Costs for Care of Developmentally Disabled Clients in Community Based and Institutional Settings 141-142 (U.C.L.A.-Neuropsychiatric Institute Research Group at Pacific State Hospital, Pomona, California, June 1977).

[25] See Miller, *Deinstitutionalization and Mortality Trends for the Profoundly Retarded*, in RESEARCH WITH THE PROFOUNDLY RETARDED, vol. 1 (C. Cleland ed. 1975).

[26] Longitudinal Study of the Court—Ordered Deinstitutionalization of Pennhurst: Historical Overview I, at 88 (Report to U.S. Department of Health and Human Services submitted by Govern-

tenable for a great many of these individuals; they are in an institution because "there is no other way to care for them." [27]

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ment Studies and Systems, Philadelphia, Pennsylvania, April 7, 1980). Also instructive in this regard is the following description of the entry requirements which ENCOR, a system of CLAs in Nebraska, established for some of its facilities:

> They included such things as: (1) must have self-help skills; (2) must be able to use public transportation; (3) must be independently employed; (4) must be capable of independent living; (5) must be able to handle money. In effect, we very neatly excluded any person who happened to be moderately, severely or profoundly retarded, or who had not yet developed one or all of those skills.

Skarnoulis, *Least Restrictive Alternatives in Residential Services,* JOURNAL OF THE AMERICAN ASSOCIATION FOR THE EDUCATION OF THE SEVERELY PROFOUNDLY HANDICAPPED, vol. 1, issue 3 (January, 1976).

[27] R. ISAACSON, *supra* at 151. See also *id.* at 15, 87; Tizard, *supra*; at 294-295. In recent years, as deinstitutionalization of the mentally retarded has increased, so has the number of readmissions to institutions, such that the "higher relase rates appear to be largely offset by soaring readmissions." J. Conroy, *Trends in Deinstitutionalization of the Mentally Retarded,* 15 MENTAL RETARDATION 46 (August 1977). According to a leading study, the "failure rate" of mentally retarded people who leave the institution (i.e., the proportion who are later readmitted) was only about 10 percent in the period 1936-1953, but it soared to nearly 50 percent in the period 1960-1970. R. McCarver and E. Craig, *Placement of the Retarded in the Community: Prognosis and Outcome,* 7 INTERNATIONAL REVIEW OF RESEARCH IN MENTAL RETARDATION 145, 180-186 (1974). Another study found that the rate of readmissions directly from CLAs to institutions more than doubled between 1977 and 1979. Scheerenberger, *supra* note 3 at 31. Although one study found a lower readmission rate, the study was limited to facilities selected from among only certain types of CLAs—excluding, for example, all nursing homes—and the facilities selected had virtually no profoundly retarded residents. E. GOLLAY, et al., COMING BACK 26 (1978).

3. A System Relying More Heavily on CLAs Would Be Unstable and Inadequately Monitored and Would Not Assure Continuity of Care.

Apart from the limitations of CLAs which have already been noted, massive transfers from public institutions to CLAs would introduce dangerous instability into the system of services for the retarded. Over 90% of CLAs are privately owned,[27a] and unlike larger state institutions, these small enterprises frequently go out of business. "Independent operators, often married couples seeking additional sources of income, offer little assurance of long-range stability. The disruptive impact to the retarded . . . of precipitate closings can be very devastating." Begab, *supra*, at 112.[28]

CLAs also are plagued with enormous staff turnover. In the five-county area served by Pennhurst, the average duration of employment of a CLA staff person is 6 months.[29] CLAs are less desirable places of employment than large institutions: they provide no privacy for staff members,[30] pay lower salaries (in the five-county area, 30% lower than institutions), and offer no career ladder.[31] New, untrained employees are continually brought in, creating "an unstable environment in the residence . . . disruptive to the expectations of the residents."[32] And as the decision below would result in increased transfers to CLAs of those retarded

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[27a] R. Bruininks, et al., *supra* note 1 at 64.

[28] Parents and advocates of retarded people who presently live in institutions are justifiably concerned that the CLAs into which many retarded people will be transferred "may not be permanent fixtures in the provider landscape and that retarded individuals will suffer from any dislocation in provider continuity." Longitudinal Study, *supra* note 26, at 87.

[29] *Id.* at 84.

[30] "Because most CLA staff live in the homes, they are constantly in contact with the residents and even though they have their own bedrooms, are unable to get away by themselves for more than short periods of time." *Id.* at 85.

[31] *Id.* at 85-86.

[32] *Id.* at 85.

people with the most severe problems—a group which CLAs have not generally accommodated in the past—the instability already present in the CLA system would almost certainly grow.[33]

Moreover, it would be extremely difficult to ensure adequate controls and accountability in a system based primarily on CLAs. Although strict monitoring of CLAs is critical,[34] in practice there is virtually no governmental supervision of CLAs. Pennsylvania has *no* regulations governing CLAs.[35] Nationwide, less than half the CLAs for the mentally retarded are subject to any licensing requirements with respect to their programs;[36] more than a quarter are not even subject to licensing requirements with respect to hygiene.[37]

Nor is this likely to change. Given the obvious difficulties of devising any adequate system for monitoring the thousands of CLAs, and the economic interests of CLA operators in avoiding such controls, a shift to CLAs simply rep-

[33] At present some sixty to seventy thousand retarded people live in CLAs nationwide. R. Bruininks, *supra* at 43. More than twice that number live in institutions. See note 3 *supra*.

[34] As noted, 90% of CLAs are privately owned. And some 38% are run for profit, according to a recent survey. Bruininks, *supra*, at 64. In his study of CLAs in Southern California, Edgerton concluded that the "primary source" of the generally poor quality of the CLAs was the "profit motive." *Issues Relating to the Quality of Life, supra*, at 131. As he observed, the interests of the management and staff of a CLA are often adverse to those of their clients. The staff may seek to create a "covert culture in which incompetence and dependence are rewarded," due to a desire to retain residents who could properly be released. *Id.* at 132. But while the management and staff seek to avoid "empty beds" (id. at 131), they may also have an interest in cutting corners on the more costly and taxing services that many retarded individuals require.

[35] Longitudinal Study, supra note 26 at 141.

[36] O'Connor, Home is a Good Place 26 (Monograph of the American Association of Mental Deficiency, No. 2, 1976).

[37] *Ibid.*

resents a means for many states to get out of the business of caring for the mentally retarded.[38]

A widespread movement to CLAs from large institutions would mean replacing state-operated facilities, which are subject to public oversight and constitutional standards, with a far-flung network of essentially private enterprises, many of them designed for profit, subject to no meaningful system of controls or accountability, nor, arguably, to constitutional obligations.

The validity of these concerns is borne out by recent history:

> When the deinstitutionalization movement began, there immediately followed the creation of large nursing homes and boarding homes in old, decaying neighborhoods where individuals were and are still isolated emotionally and socially from the community. . . . In some cases, rather than being 'dumped' in the back wards of institutions, the mentally disabled have been 'dumped' in the back alleys of communities where facilities are inadequate and services inaccessible.

Detroit Research Institute, The Illusion of Deinstitutionalization 3 (University of Denver, October 1978). See also AFSCME, Patients for Sale, *supra;* Comptroller General's Report, *supra* note 1.[38a]

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[38] For evidence that this indeed is occurring, see A. SCULL, DECARCERATION 150-151 (1977); American Federation of State, County and Municipal Employees, Patients for Sale 18-25 (Preliminary Draft, May 27, 1980).

[38a] In the end, the assumptions of the court below are perhaps most tellingly refuted in the letters of parents of Pennhurst residents filed with the courts below. One parent wrote:

> Let me first say that I cannot understand how Judge Broderick could make such a "blanket" ruling in regards to our retarded children. Each one has his special abilities and disabilities and if it were possible for them to function in the outside world, most parents would have kept them at home.
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> * * * *
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> In 1968 Pennhurst was overcrowded and short handed and yes there were many problems. But today, Pennhurst has

II. THE WORDS, STRUCTURE AND LEGISLATIVE HISTORY OF THE STATUTE, VIEWED AGAINST THE REALITY JUST DESCRIBED, AFFORD NO SUPPORT FOR CONSTRUING THE STATUTE TO CREATE A PRESUMPTION IN FAVOR OF DEINSTITUTIONALIZATION.

The court below found the "presumption" in favor of CLAs in the words of § 6010(2) of the Act, specifically in the following "finding[] respecting the rights of persons with developmental disabilities":

> The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the development potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.

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changed greatly. About seven years ago when the New Horizon Bldg. was built, our son was transferred there to Ward 48 and he has had good care. Here is a 29 year old child who needs 24 hr. care and protection. He does not talk, cannot dress himself and needs help at mealtime. He is not toilet trained and is on a 2 hr. schedule for bathroom needs. His mental age is about 1½ years. He does walk but due to some palsy, his gait is uneven. He is subject to petit and grande mal seizures but medication keeps his condition under control. He cannot think for or take care of himself.

In this building, there are heated swimming pools and my son is taken there and carefully guarded. He is taken on outings such as the Zoo, Seashore, Hershey Park, etc. There is also a fenced play area in the rear of the building.

He has room to walk the halls, a large playroom with T.V.-cartoon movies are shown and he has more freedom than if he were placed in a small apartment or home in our noisy, crowded crime ridden city. Most parents send their children to the country to get them away from the city and the underprivileged children are also sent to camps and yet Judge Broderick wants to send my handicapped child back to Phila.

* * * *

I know my son—a small cramped environment is not good for him. He becomes frustrated and high strung. He needs security of the attendants he has known these past years and

The court of appeals, believing from the distorted record made by the parties in the district court (see Motion, p. iv *supra*) that CLAs are always less "restrictive of . . . personal liberty" than institutions, understood these words to create a presumption in favor of placement in CLAs. But, as as we have shown (pp. 6-9 *supra*), it is simply not true, particularly for seriously retarded persons (and it is they who make up most of the population of institutions) that CLAs will necessarily be less restrictive of personal liberty; indeed, in many cases CLAs will be more restrictive, and in still others the answer will depend upon the relative quality and programs of the institution and the CLA between which the choice must be made. Nor is there reason to attribute to Congress, which has held lengthy hearings over a period of years, the misconceptions which guided the courts below.[39]

Congress did not in terms dictate a preference for CLAs; rather, it expressed a preference for "the setting" which is least restrictive of "the person's" personal liberty. These

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cannot take too much noise or confusion and he will certainly get this if he is moved to some small place in Phila. These attendants, nurses and doctors are his parents.

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Letter submitted to the court of appeals as an exhibit to the "Brief in Response to the Court's Request," dated August 15, 1979, by petitioner Pennhurst Parents-Staff Association. Numerous other letters expressing similar concerns, which were filed with the district court, were included in the Supplemental Appendix of the Pennhurst Parents-Staff Association in the court of appeals.

[39] The committees responsible for the enactment and amendment of the statute conducted several series of hearings in which a wide range of issues regarding habilitation of the mentally retarded were explored in depth. See *Hearings on S. 427 and S. 458 before the Subcomm. on the Handicapped of the Sen. Comm. in Labor and Public Welfare*, 93d Cong., 1st Sess. (1973); *Hearings on H.R. 11511 before the Subcomm. on Public Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 93d Cong., 2d Sess., pts. 1 and 2 (1974); *Hearings on H.R. 2954, etc. before the House Subcomm. on Public Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 94th

words call for examination of each person as an individual, and the selection of "the setting" which is least restrictive for that person. Assuming *arguendo* that this was meant to be a judicially enforceable command, there is no warrant for injecting a presumption which effectively predetermines the outcome.

Moreover, even the "least restrictive" language upon which the court below focused is not unqualified. It is but one of two intertwined objectives declared in the same sentence: the "treatment, services, and habilitation" for a retarded person "should be designed to maximize the development potential of the person *and* should be provided in the setting that is least restrictive of the person's personal liberty." As we have shown (pp. 9-18 *supra*), it will often be the case that CLAs are incapable of providing the treatment and services designed "to maximize the development potential of the person." In such instances, the statute does not express a preference for CLAs *even if* they are less "restrictive of . . . personal liberty." Rather, the "least restrictive" criterion is operative only in selecting from among those "settings" which are able to provide the "treatment, services, and habilitation . . . designed to maximize the development potential of the person." [39a]

Cong., 1st Sess. (1975); *Hearings on S. 3378 before the Subcomm. on the Handicapped of the Sen. Comm. on Human Resources,* 94th Cong., 1st Sess. (1975); *Hearings on S. 462 before the Subcomm. on the Handicapped of the Sen. Comm. on Human Resources,* 94th Cong., 1st Sess. (1975); *Hearings on S. 2600 before the Subcomm. on the Handicapped of the Sen. Comm. on Human Resources,* 95th Cong., 2d Sess. (1978).

[39a] In fact, § 6010 declares several other preferences in addition to the preference for treatment and services which "maximize . . . development potential" and are provided in the "least restrictive" setting, all of which may bear upon the proper placement of an individual. Treatment and services are to be "appropriate" (§ 6010(1)); the Federal Government and the States "have an obligation to assure that public funds are not provided to any institution or other residential program" for retarded people which does not meet certain requirements with respect to diet,

In sum, § 6010(2), read in light of the specialized world to which it is addressed, expresses a preference that each retarded person receive the individualized treatment best suited to his particular condition, in "the setting" best capable of providing that treatment without unnecessary obstruction of personal liberty. If courts are to implement this preference, they should do so freed of presumptions in favor of some settings over others—presumptions which there is no evidence Congress meant to create.

We have shown that a presumption favoring CLAs cannot be found in the section of the Act—§ 6010(2)—where the court below purported to find it. Other provisions of the Act corroborate that Congress did *not* intend such a presumption. There is only one provision of the Act which distinguishes between institutions and CLAs: § 6063, which sets the criteria to be met by the "State plans" that must be approved by the Secretary of Health and Human Services as a condition to a State's receipt of funds under the Act.[40] Section 6063 designates "four different areas of priority

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medical and dental services, use of physical and chemical restraints, opportunities for relatives to visit, and compliance with fire and safety standards (§ 6010(3)); and "all programs . . . should meet standards which are designed to assure the most favorable possible outcome for those served," and which comply with certain specified standards including, "in the case of residential programs serving persons in need of comprehensive health-related, habilitative, or rehabilitative services," standards which are at least equivalent to certain standards promulgated under the Medicaid program, "as appropriate when taking into account the size of the institutions and the service delivery arrangements of the facilities of the programs," and, "in the case of other residential programs for persons with developmental disabilities," standards which assure that care is "appropriate to the needs of the persons being served," that "the persons admitted to facilities of such programs are persons whose needs can be met through services provided by such facilities," and that the facilities provide for "humane care . . ., are sanitary, and protect [the] rights" of those they serve (§ 6010(4)).

[40] See 42 U.S.C. § 6063(a). Noncompliance with these criteria subjects a State to withholding of funds. See 42 U.S.C. § 6065.

services,'' [41] and requires the State to select one, or at most two, of these areas as the focus of its expenditures of Federal funds.[42]

Of the four areas of ''priority services'' designated in the Act, the only one which focuses upon CLAs is ''alternative community living arrangement services,'' defined by the statute to mean ''such services as will assist persons with developmental disabilities in maintaining suitable residential arrangements in the community, . . . includ[ing] in-house services such as personal aides and attendants and other domestic assistance and supportive services, family support services, foster care services, group living services, respite care, and staff training, placement, and maintenance services.'' [43] Each of the other areas of ''priority services'' is concerned with the development of specific types of programs and services—''case management services,'' ''child development services,'' and ''nonvocational social-development services''[44]—which the State is free to implement exclusively in institutions if it chooses.

Thus, *under the terms of the Act, a State is free to apply all of its federal funds to improving institutions, and is under no requirement to utilize any of the funds to establish or expand CLAs.* The State must ''examin[e] . . . the need'' in the State for the four areas of priority services,[45] but only if the State *chooses* to make ''alternative community living arrangement services'' one of the areas of focus in its State plan must the State devote a portion of its federal funds to providing such services.[46] And, even if a State

[41] 42 U.S.C. § 6063(B)(4)(A)(i).

[42] 42 U.S.C. § 6063(b)(4)(A)(ii), (B)(ii)(I). See also 45 Fed. Reg. 31006, 31020-21 (1980) (proposed regulations to be codified at 45 C.F.R. §§ 1386.45-47). In years where the federal appropriation exceeds $60 million a state may, if it chooses, select as many as three priority areas for funding. 41 U.S.C. § 6063(b)(4)(B)(ii)(II); 45 Fed. Reg. 31020.

[43] 42 U.S.C. § 6001(8)(E).

[44] These terms are defined in § 6001(8)(C), (D) and (F).

[45] See 42 U.S.C. § 6063(b)(4)(A)(i).

[46] See 42 U.S.C. § 6063(b)(4)(B).

makes that choice, the funds it devotes to such services need not be used to transfer residents from institutions to CLAs; the funds can be used to improve the programs for existing residents of CLAs, or even simply to improve "family services."[47]

Thus, while Congress regarded the development and improvement of CLAs as one area which a State *could* choose to emphasize, it made funds equally available to those States which choose to use all of the funds to improve services at larger state institutions. Since these are the only provisions of the Act which speak directly to any distinction between institutions and CLAs, and since they reflect the judgment of Congress as to the habilitation programs which the States should be encouraged to pursue, the fact that these provisions do not require any deinstitutionalization whatsoever is powerful corrobative evidence that the Act is not intended to establish the presumption in favor of CLAs fashioned by the court of appeals.[48]

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[47] The definition of "alternative community living arrangement services" does not specifically refer to the transfer of residents from institutions to CLAs; rather, it refers to the provision of services which will assist retarded persons "in *maintaining* suitable residential arrangements," including such matters as "family support services" as well as services to improve existing CLAs. § 6001 (8)(E). Indeed, the funds which a State earmarks for "alternative community living arrangement services" can even be spent on improving certain programs of *institutions,* rather than CLAs. The expenditure rules in § 6063(b)(4)(B) apply to "service activities in . . . areas of services specified in the [State] plan;" and "[f]or purposes of this subparagraph, the term 'service activities' includes, with respect to an area of services . . . activities to increase the capacity of *institutions* and agencies to provide services in the area . . . ." 42 U.S.C. § 6063(b)(4)(B)(iv) (emphasis added).

[48] The provisions of § 6063 regarding planning and expenditures, adopted in 1978, replaced earlier provisions which *did* refer specifically to the transfer of certain retarded people from institutions to CLAs. The earlier provisions, adopted in the 1975 amendments to the statute, required each State to earmark a designated percentage of the funds received under the Act "for the purpose of assisting

CONCLUSION

Amici welcome, as much as any party to this case, the increased concern which has been focused in recent years on the needs of retarded people. As a result of this awakened attention, community-based services are being made

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it in developing and implementing plans designed to eliminate inappropriate placement in institutions of persons with developmental disabilities." P.L. 94-103, § 131(a)(4), 42 U.S.C. § 6062(a)(4) (1976) (repealed). Each State plan was required to include provisions "designed (A) to eliminate inappropriate placement in institutions of persons with developmental disabilities, and (B) to improve the quality of care and the state of surroundings of persons for whom institutional care is appropriate." P.L. 94-103, § 111(b)(20), 42 U.S.C. § 6063(b)(20) (1976) (repealed). And, the State plans were required to "support the establishment of community programs as alternatives to institutionalization and support such programs which are designed to provide services for the care and habilitation of persons with developmental disabilities, and which utilize, to the maximum extent feasible, the resources and personnel in related community programs to assure full coordination with such programs and to assure the provision of appropriate supplemental health, educational, or social services for persons with developmental disabilities." P.L. 94-103, § 111(b)(23), 42 U.S.C. § 6063(b)(23) (1976) (repealed).

While these provisions were designed to encourage the elimination of "inappropriate placements," they contained no presumption that any particular placement was in fact inappropriate. Nor could the requirement that the States "support the establishment of community programs as alternatives to institutionalizaion" have been read to establish such a presumption. The Conference Report on the 1975 amendments recognized that "the development of community resources to serve previously institutionalized individuals would be an appropriate purpose for which funds could be expended" (H.R. Rep. No. 94-473, 94th Cong., 1st Sess. 33 (1975); and Congress expected that the statute would "prompt some movement of patients from State institutions back into their communities." H.R. Rep. No. 94-58, 94th Cong., 1st Sess. 10 (1975). But that is a far cry from the ruling below, under which courts are to direct transfers in all but the "extreme situation."

More importantly, the court's construction must be tested by the provisions of the statute which are in effect today. See, e.g.,

available to those who can benefit from them; and equally important, institutions for the retarded, many of which had been allowed to decay to an intolerable degree, are being revitalized as "active training, educational, and socialization centers." [49]

To consign institutions to a disfavored status in the system of services for the mentally retarded, on the mistaken assumption that community living arrangements are presumptively a superior means of habilitation for those retarded people who are presently institutionalized, would be a serious mistake. As Dr. David Rosen, the President of the American Association on Mental Deficiency, advised Congress:

> [W]e must realize that some people are, in fact, best served for appropriate periods, not necessarily for life, in what we generally think of as institutions. For

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United States v. *Alabama*, 362 U.S. 602, 604; *Hines* v. *Davidowitz*, 312 U.S. 52, 60; *Carpenter* v. *Wabash Ry. Co.*, 309 U.S. 23, 26-27; *American Foundries* v. *Tri-City Council*, 257 U.S. 184, 201. The provisions of the current Act do not contain any reference to "inappropriate placements" or to "the establishment of community programs as alternatives to institutionalization." The sections of the 1975 amendments which did so have been replaced by the statutory scheme discussed in the text. Thus, to the extent that the 1975 amendments could have been read to provide any support for the holding of the court below, the fact that Congress *eliminated* the relevant provisions of those amendments in 1978 only reinforces the conclusion that the decision of the court of appeals is unsupportable as a construction of the statute on the books today.

[49] P. Roos, *Evolutionary Changes of the Residential Facility*, *supra* note 14, at 36. For other discussions of the prospects for improvement of institutions, see M. Rosen, et al., *An Institution Transformed*, in HABILITATION OF THE HANDICAPPED, *supra* at 61-74; J. Clements, *Planning a Residential Facility for the Mentally Retarded*, in RESIDENTIAL FACILITIES, *supra* note 14 at 59-116; C. Blue, *Education of the Mentally Retarded in Residential Settings*, *supra* note 23 at 272, 276-277; K. Kreger, *Compensatory Environment Programming for the Severely Retarded Behaviorally Disturbed*, *supra*. And see pp. 20, 21, *supra*.

these people, we need to be assured that effective current programs are continued and that new and better ones are developed.[50]

The decision below, insofar as it establishes a presumption in favor of court-ordered deinstitutionalization, should be reversed.

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[50] *Hearings on H.R. 11511, etc. before the Subcomm. on Public Health and Environment of the House Comm. on Interstate and Foreign Commerce* 1046 (93d Cong., 2d Sess. 1974).

Supreme Court, U.
AUG 21 1980
MICHAEL RODAK, JR.

NO. 79-1404, 79-1408, 79-1415 and 79-1489

Supreme Court of the United States

OCTOBER TERM, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,

Defendant-Appellants

v.

TERRI LEE HALDERMAN, et al.,

Plaintiff-Appellees

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF OF THE STATE OF CONNECTICUT AS AMICUS CURIAE IN SUPPORT OF THE DEFENDANT-APPELLANTS

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QUESTIONS PRESENTED AND DISCUSSED BY AMICUS

1. Whether the Court below construed the Act in a manner which will require federal intervention into the states' determinations regarding the nature, structure, fiscal feasibility and location of services to the retarded, and therefore violates principles of federalism embodied in the Tenth Amendment of the United States Constitution?

2. Whether the Court below erred in concluding that the Act provides the developmentally disabled with a legal entitlement to treatment which must be rendered in the least restrictive alternative?

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OPINIONS BELOW

The opinion of the United States Court of Appeals for the Third Circuit appears at 612 F. 2d 84.

The opinion and order of the United States District Court for the Eastern District of Pennsylvania both appear at 446 F. Supp. 1295.

CONSENT OF THE PARTIES

Consent of the parties is not required since this brief of the State of Connecticut as Amicus Curiae is sponsored by its Attorney General U.S. Sup. Ct. R. 36.

INTEREST OF AMICUS CURIAE

The State of Connecticut renders necessary services to its retarded citizens. A wide variety of services are offered including evaluation and testing, counseling, respite care, day care, special school districts, supervised apartments, independent apartments, independent living programs, group homes, regional centers and state schools for the retarded.

In 1973 the Connecticut Department of Mental Retardation undertook an extensive evaluation of the services that were provided and of the Department's goals for the future. The resulting plan,[1] which was updated in 1979, committed the Department to moving in the direction of community based

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[1]The plan represents the views of the Connecticut Department of Mental Retardation and requires extensive funding from the State Legislature to be implemented.

services.[2] The Department, however, recognizes that a variety of residential treatment options must be maintained in order to meet varying individual needs and that an adequately staffed and competently managed state school for the retarded ramains the most appropriate placement for many of Connecticut's retarded citizens.[3] Although Connecticut has been responsible in meeting the needs of its citizenry, the Department lacks the resources to meet the needs of all of the retarded that are in need of residential treatment services. Accordingly, two hundred seventy-eight (278) retarded citizens were on the Department's "urgent waiting list" for residential treatment services as of August 1, 1980.[4]

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[2]The planning document states the Department's goal that:

> "DMR will assure that the residential needs of the mentally retarded citizens of Connecticut are met. The Department will follow the principle of normalization in meeting these residential needs. This means that each retarded citizen will live in an environment which: 1) reflects as nearly as possible 'normal' living situations of the larger society commensurate with his/her individual needs; 2) secures his/her health, safety, and welfare; 3) promotes the maximum development of his/her potential to make full use of that environment."
>
> Project Challenge, Residential Services Plan of the Connecticut Department of Mental Retardation (1979) p. 38.

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[3]The plan provides that:

> "(T)he Department's goal is stated in Project Challenge is to provide a variety of options that will effectively meet the *individual* needs of the mentally retarded. The very nature of mental retardation demands these options. As community attitudes change and the necessary support systems are developed, the young retarded person will, for the most part, be able to live in the community throughout his lifetime. For many individuals, because of their specific needs, relocation into the community is often very difficult and the campus programs of the training schools and regional centers will no doubt continue to be the most appropriate and humane place for them."
>
> Project Challenge, *supra*, Introduction.

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[4]A relatively small number of retarded citizens are committed to the care of the Department pursuant to the Connecticut civil commitment statutes, Conn. Gen. Stat. §17-176, *et seq*. Typically, the Department responds to emotional pleas for help when a family in crisis can no longer cope with the demands of a retarded family member.

The court below broke new ground in federal-state relations concerning the care of the retarded in at least two respects:

1) By ruling that the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000, et seq. (hereinafter the "DD Act" or the "Act"), requires the states to render services to all of its developmentally disabled citizens, and

2) By requiring the services to be rendered in the least restrictive environment.

If the decision of the court below is affirmed, or followed by the remaining Circuits, the states will be required to provide services, regardless of cost, to all its developmentally disabled citizenry and in the manner that is mandated by the federal judiciary.[5]

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[5]The Brief of the United States in Opposition to the Grant of Certiorari, at p. 14, asserts that the court:

> "... concluded that when the State accepts responsibility for the care of the mentally disabled and accepts federal funding under the Act to assist in performing that responsibility, it must provide that care in a manner consistent with the Act. The court did not consider, much less adjudicate, the quite different question whether the state must provide for the care of all its mentally disabled citizens."

The United States is correct only to the extent that the decree is necessarily limited to parties to the action. *Amicus* notes, however, that the definition of the plaintiff class, whose rights were adjudicated, included those "who may become residents of Pennhurst," 612 F.2d at 89, i.e., the plaintiff class includes by definition those who are not currently receiving services. Second, the Order of the District Court, which was not modified by the Court below, enjoined the state and county defendants to provide community living arrangements to those currently *on Pennhurst's waiting list* and appointed a special master who was required to formulate a plan to habilitate "*all plaintiffs* in the least separate, most integrated, least restrictive community setting ..." 446 F. Supp. at 1326, 1327. See generally, Paragraphs 1, 2, 3, 6(a)-(g) of the Order of the District Court, *id.*, wherein the District Court clearly indicates that its Order extends to all retarded citizens in the geographical area served by the Pennhurst State School. Third, the Act which the Court below construed ambiguously declares a finding of a "right of treatment" without limiting the right to those who are currently receiving services. Fourth, the section of the opinion of the Court below that found a "right to treatment" did so without any indication that the "right" was limited to those who are

If the decision below is affirmed, the most immediate impact on Connecticut will be to question the continued viability of Connecticut's "campus programs", which serve approximately three thousand Connecticut citizens.[6] As noted, *supra*, the Connecticut Department of Mental Retardation is committed to moving in the direction of community services, but maintains that campus programs will continue to be necessary for a significant number of Connecticut's citizens. If the Act requires community based services as the "least restrictive alternatives" not only will Connecticut's judgment as to the most appropriate care for its severely retarded multiply-handicapped citizens be supplainted by federal policies, but Connecticut will be required to expend significant sums to provide the required community based facilities. The cost of non-institutional housing is difficult to estimate because it is rapidly escalating and because it varies from region to region. The Department's most recent calculations, however, indicate that new construction costs an average of $37,322.42 per client bed, while purchased renovated group homes cost an average of $26,339.29 per client bed. Given the rapidly rising costs of construction, the initial capital costs of moving a significant number of the three thousand (3,000) Connecticut citizens in the campus programs to community living arrangements would be well in excess of ninety million dollars ($90,000,000.00). In addition, significant increases in annual operating costs will accrue due to the necessity of providing increased direct care staff and medical and psychological support services over a geographically diverse area.

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currently receiving services. See 612 F.2d at 95-100. Finally, the remedy ordered by the Courts below requires that there be a "right to treatment" since if the Act is limited to instances ". . . when the state accepts responsibility for the care of the mentally disabled . . .," the Courts would have been limited to enjoining the continued operation of the facility rather than mandating alternative community living arrangements.

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[6]Connecticut maintains two state schools for the retarded, the Mansfield Training School and the Southbury Training School, which serve 986 and 1326 retarded citizens respectively. In addition, 644 retarded citizens reside in campus programs at eight different regional centers.

Connecticut, like all of the fifty states, participates in the DD Act program, receiving federal funds under the Act to render services in accordance with its state plan, which has been approved by the Department of Health, Education and Welfare (HEW). Only approximately three hundred ninety-eight thousand ($398,000) dollars in federal monies was received under the Act for the fiscal year ended September 30, 1979. All of the monies received under the Act are utilized to provide community based services.[7]

Finally, Connecticut is "interested" in this action since there are several lawsuits pending in the U.S. District Court for the District of Connecticut which involve claims by developmentally disabled citizens that their rights under the Act are not being met. Most notably, *Connecticut Association for Retarded Citizens vs. Mansfield Training School*, No. H-78-653 (D. Conn. filed December 6, 1978), is a class action lawsuit, closely patterned after *Halderman vs. Pennhurst*, wherein the plaintiffs seek to close a state school for the retarded and to require that the State provide alternative community living arrangements for its residents.[8]

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[7]The District Court in *Halderman* made no findings as to the DD Act. The Supplemental Memorandum of the Commonwealth of Pennsylvania before the Third Circuit Court of Appeals, dated August 15, 1979, p. 1-7, however, indicates that no DD Act funds are utilized at Pennhurst.

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[8]The facility that is the subject of the action, the Mansfield Training School, has reduced its population from approximately two thousand (2,000) ten years ago to nine hundred eighty-six (986) today. The Department plans to continue reducing its population until it serves four hundred eighty (480) residents, Project Challenge, *supra*, p. 39, and to convert the facility into an entirely ICF/MR facility, i.e. all of the living units will meet federal standards for reimbursement under the Title XIX medicaid program.

STATEMENT OF THE CASE

This is a class action lawsuit, brought on behalf of all current and future residents of the Pennhurst State School and Hospital, alleging that the facility is operated in a manner that violates its mentally retarded residents' constitutional and statutory rights.

After an extensive trial, the District Court (Broderick, J.) found that the facility violated its residents' constitutional rights to "habilitation", *Halderman v. Pennhurst State School and Hospital*, 446 F. Supp. 1295, 1314, 1321 (E.D. Pa. 1977), as well as their statutory right to "nondiscriminatory habilitation" under Section 504 of the Rehabilitation Act, 29 U.S.C. §794. *id.* at 1323. Rather than ordering that the facility be improved, the District Court ordered that the facility be closed and a master was appointed to supervise the transfer of residents into the community. *id.* at 1325.

On appeal, the Third Circuit Court of Appeals largely affirmed the relief ordered below, but relied on an entirely different legal approach than the District Court. *Halderman v. Pennhurst State School and Hospital*, 612 F. 2d 84 (3rd Cir. 1979). The majority ruled that Congress was legislating to implement the Fourteenth Amendment when it passed the DD Act, *id.* at 98, and that the Act provided the developmentally disabled with a right to habilitation, *id.* at 95, which must be provided in the setting that is least restrictive to personal liberty. *id.* at 107.

SUMMARY OF ARGUMENT

Contrary to the opinion of the Court below, the Act was not passed to implement the Fourteenth Amendment since: 1) the legislative history of the Act indicates that it is a co-operative grant program; 2) the Act, as construed by the Court, below, is not "appropriate" legislation to implement the Fourteenth Amendment in that it goes well beyond the judicially declared limits of the Fourteenth Amendment; and 3) the Act is inconsistent with those lower court decisions that have found a *quid pro quo* right to treatment under the Fourteenth Amendment. Since the Act was not passed to implement the Fourteenth Amendment, it is not necessary to consider whether legislation implementing the Fourteenth Amendment overrides the Tenth Amendment.

The Act, as construed by the Court below, impermissibly interferes with traditional state functions in violation of the Tenth Amendment, in that it dictates who is to receive services from the state (all of the developmentally disabled) and the manner by which the services are to be rendered (the least restrictive alternative).

The difficult constitutional issues raised by the opinion of the Court below are a result of an erroneous construction of the Act which is, in fact, a co-operative grant program with specified obligations placed upon the states. The Court below erroneously concluded that a Congressional "finding" of the rights of the disabled created an obligation upon the states, which holding is inconsistent with the Act, its legislative history and the implementing regulations.

ARGUMENT

I. The Decision of the Court Below Construes the Act in a Manner Which Will Require Federal Intervention into the States' Determinations Regarding the Nature, Structure, Fis-

cal Feasibility and Location of Services to the Retarded, and Therefore Violates Principles of Federalism Embodied in the Tenth Amendment of the United States Constitution.

A.

The Act was not passed pursuant to Congress' power to implement the Fourteenth Amendment.

1. As noted, *supra*, the Court below held that the DD Act was passed pursuant to Congress' power to implement the Fourteenth Amendment.

The only support that the Court below offered for their conclusion that Congress intended to legislate pursuant to the Fourteenth Amendment is the remarks of two Senators, neither Chairman of the Subcommittee that introduced the legislation, as to Senate Bill 462. 612 F. 2d n. 17 at 98. The Bill subsequently went to conference where the "rights" provided by Senate Bill 462 were compromised. See, H.R. Conf. Rep. 94-473, 94th Cong., 1st Sess. p. 41, 42, *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 943, 961, 962.

Even the remarks of the two individual Senators do not support a finding that the DD Act was enacted pursuant to Congress' power to implement the Fourteenth Amendment. Senator Stafford's remark is that, "Title II was added to the bill to assist in the protection of rights guaranteed under our Constitution . . ." 121 Cong. Rec. 16516 (1975). Senator Javits remarked that the federal government had abrogated its responsibility toward the developmentally disabled, citing *Wyatt v. Stickney*, and then noted that, "Congress should reaffirm its belief in equal rights for all citizens . . . This bill of rights of S.B. 462 represents this new direction, and begins this new reaffirmation." 121 Cong. Rec. 16519 (1975). "Assistance" or a "new reaffirmation" may indicate Congressional concern and a preference for deinstitutionalization, but hardly amounts to a

federal mandate passed pursuant to the Fourteenth Amendment.

That conclusion is also inconsistent with the history of the Act, see H.R. Conf. Rep. 94-473 *supra*, and the implementing HEW regulations which indicate that Act is a co-operative federal-state grant program.

2. The Court below asserted that "Section 6010 does not go beyond what has been judicially declared to be the limits of the Fourteenth Amendment but clearly is within those bounds." 612 F. 2d at 98.

Congress clearly has the power to secure the guarantees of the Fourteenth Amendment by "appropriate legislation." *Katzenbach vs. Morgan*, 384 U.S. 641, 651 (1966). The Court below, however, failed to adequately examine whether the DD Act is appropriate legislation to secure Fourteenth Amendment guarantees.

The Fourteenth Amendment has consistently been construed as a limitation on state power to impair protected liberty or property interests, absent due process of law. Although a relatively few protected interests have been found to stem directly from the Constitution itself, this Court has repeatedly held that protected interests generally stem from independent sources, such as state law. *Board of Regents vs. Roth*, 408 U.S. 564 (1972); *Perry vs. Sinderman*, 408 U.S. 593 (1972); *Bishop vs. Wood*, 426 U.S. 341 (1976); *Paul vs. Davis*, 424 U.S. 693 (1976).

Accordingly, there is no more basis for asserting a constitutional "right to treatment" as there is to asserting a constitutional entitlement to such other governmental services as welfare, *Dandridge vs. Williams*, 397 U.S. 471 (1970), *Lavine vs. Milne*, 424 U.S. 577, 584 n. 9 (1976); education, *San Antonio Independent School District vs. Rodriguez*, 411 U.S. 1

(1973); housing *Lindsey vs. Normet*, 405 U.S. 56 (1972); or employment, *Perry vs. Sinderman, supra*, p. 597.[9]

3. Those Courts that have found a "right to treatment" have recognized that the "right" does not rise independently from the Constitution, but have found that it is due as a quid pro quo for civil commitment.[10] See for example *Wyatt v. Stickney*, 325 F. Supp. 781. *enforced*. 334 F. Supp. 1341 (1971), *supplemented*, 344 F. Supp. F. Supp. 373, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part, rev'd in part, remanded in part, sub nom. Wyatt v. Alderholt*, 503 F. 2d 1305 (5th Cir. 1974); *Donaldson v. O'Connor*, 493 F. 2d 507 (5th Cir. 1974), *vacated on other grounds and remanded*, 422 U.S. 563 (1975); *Gary W. v. Louisiana*, 437 F. Supp. 1209 (E.D. La. 1976).

This Court has not yet ruled on whether civilly committed patients have a right to treatment. In *O'Connor v. Donaldson*, 422 U.S. 563, 576 (1975), this Court narrowly ruled that, " . . . a State cannot constitutionally confine without more a non-dangerous individual who is capable of surviving safely in

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[9]The Court below cited *Ingraham v. Wright*, 430 U.S. 651, 673 (1977) for the proposition that ". . . among the liberties protected by the fourteenth amendment is 'a right to be free from and to obtain judicial relief, for unjustified intrusions on personal security.' " 612 F.2d at 98. *Ingraham v. Wright*, read together with *Donaldson v. O'Connor*, 422 U.S. 563 (1975), however, only requires that there be a justification for the confinement (i.e. for the commitment). They cannot be read as establishing a constitutional entitlement to treatment for all of the developmentally disabled (whether committed, voluntarily receiving services or not receiving services) which treatment must be rendered in the least restrictive alternative.

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[10]Cases concerning the retarded have tended to blur the distinction between the civil commitment of retardates and the voluntary rendition of necessary services at the request of the retardate, parent or legal guardian, and have assumed that any retardate in a state institution is there involuntarily. See *Halderman v. Pennhurst*, 446 F.Supp. 1295, 1319 (1977); *Wyatt v. Stickney*, 344 F. Supp. 387, 390, n. 5 (1972).That approach universally puts the burden of retarded citizens condition upon the states should the states voluntarily render services and is a questionable application of state action principles. See, *Flagg Bros. Inc. v. Brooks*, 436 U.S. 149 (1978).

freedom . . .". The right to treatment theory, however has been sharply criticized. Speece, *Preserving the Right to Treatment: A Critical Assessment and Constructive Development of Constitutional Right to Treatment Theories*, 20 Ariz. L. Rev. 1 (1978); *Connor v. Donaldson, supra*, p. 295-2500. (Burger, J.) (concurring opinion.)

Whatever its merits, the Court below turned the "right to treatment" theory on its head by holding that the DD Act, passed pursuant to Congress' power to implement the Fourteenth Amendment, obligates the states to treat all of its developmentally disabled residents and to do so in a manner that is least restrictive to personal liberties. That construction is inconsistent with the right to treatment theory, which only requires treatment as the *quid pro quo* for a deprivation of liberty.

Wherefore, the Court below erred since the Act, as construed by the Court below, is not "appropriate" legislation implementing the Fourteenth Amendment, *Katzenback vs. Morgan, supra*, because instead of limiting the states from interfering with protected rights, it affirmatively obligates the states to render services to their citizens in the manner prescribed by Congress whether or not the states desire to render such services or are fiscally able to provide such services.

B.

The Act, as Construed by the Court Below, Impermissibly Interferes with Traditional State Functions in Violation of the Principles of Federalism Embodied in the Tenth Amendment of the United States Constitution.

The Court below recognized that a Tenth Amendment issue would be presented if a private cause of action was implied from a grant program. 612 F. 2d at 98, 99. The issue was avoided by its holdings that the DD Act was passed pursuant to

Congress' power to implement the Fourteenth Amendment and that legislation implementing the Fourteenth Amendment overrides Tenth Amendment concerns.[11]

In light of the discussion, *supra*, showing that the Act clearly was not passed pursuant to the Fourteenth Amendment, it is necessary to consider whether the Act, as construed by the Third Circuit, violates the Tenth Amendment to the United States Constitution.

National League of Cities vs. Usery, 426 U.S. 833, 851 (1976), held that the Tenth Amendment bars the federal government from impermissibly interfering with traditional governmental functions of the States. *National League of Cities* concerned the validity of 1974 Congressional legislation under the commerce clause which extended minimum wage and maximum hour provisions of the Fair Labor Standards Act to the states. The Court noted that "(i)f Congress may withdraw from the States the authority to make those fundamental employment decisions upon which their systems for performance of these (traditional state) functions must rest, we think there would be little left of the States' separate and independent

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[11]Several lower courts have held that legislation implementing the Fourteenth Amendment overrides Tenth Amendment concerns. The reported cases involve legislation unlike the DD Act in that the statutes were clearly "appropriate" to implement the Fourteenth Amendment since the legislation barred the states from treating similarly situated citizens differently. See for example, *Arritt v. Grisell, 567 F.2d 1267* (4th Cir. 1977) (Age Discrimination in Employment Act, 29 U.S.C. §623, implements the Fourteenth Amendment and supersedes the Tenth Amendment); *Marshall v. Owensboro-Daviess County Hospital*, 581 F.2d 116 (6th Cir. 1978) and *Usery v. Charlestown County School District*, 558 F.2d 1169 (4th Cir. 1977) (Equal Pay Act, 29 U.S.C. §206(d)(1), implements the Fourteenth Amendment and supercedes the Tenth Amendment).

The lower court cases, upon examination, stand for the proposition that appropriate legislation will overcome Tenth Amendment concerns when,on balance, the federal interest outweighs the impact on the states. Assuming *arguendo* that the DD Act is "appropriate", its impact must still be examined on the retained right of the states to structure the nature and scope of service provided.

existence;" 426 U.S. at 851 citing to *Coyle v. Oklahoma*, 221 U.S. 559 (1911), and held that "insofar as the challenged amendments operate to displace the States' *freedom to structure integral operations in areas of traditional governmental functions*, they are not within the authority granted Congress by Art. I, §8, cl. 3" 426 U.S. at 852 (emphasis added).

Subsequent lower Court decisions have held other activities to be within the protected sphere of state sovereignty. *United States v. Best*, 573 F. 2d 1095, 1102 (9th Cir. 1978) (licensing of drivers is a traditional state function); *N.L.R.B. v. Highview, Inc.*, 590 F. 2d 174, 178 (5th Cir. 1979) (the care of the aged, sick and the indigent is a traditional state function); *Jordan v. Mills*, 473 F. Supp. 12 (E.D. Mich 1979) (operation of prisons is a traditional state function).

Clearly, care of the retarded has traditionally been reserved to the states in their role as *parens patriae*. *Parham v. J.R.*, U.S. , 99 S. Ct. 2493 (1979); *Addington v. Texas*, U.S. , 99 S. Ct. 1804 (1979); *McIntosh v. Dill*, 86 Okl. 1 (1922); *Johnson v. State*, 18 N.J. 422 (1955).

Just as clearly the Act, as construed by the Court below, interferes to an unprecedented degree with the states' retained right to structure the services that they provide by dictating who is to receive the services (all of the developmentally disabled) and the manner by which the services are to be rendered (in the least restrictive manner, as ultimately determined by the federal judiciary.[12]

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[12]If the DD Act is a co-operative grant program, as this *amicus* maintains, there is no qustion about the power of Congress to attach *reasonable* conditions to the receipt of federal funding. *King v. Smith*, 392 U.S. 309 (1968). There are two implications, common to all grant programs, however: 1) the states may withdraw or decline to participate if they so choose; and 2) the states, that participate, may only be required to provide those services that are mandatory on the states, as opposed to services that are appropriate and reimbursable under the Act, but left to the discretion of the states as to

If the Court below correctly construed the Act, and the validity of the Act is upheld by this Court on review, the role of the states has been reduced to administering (*and funding*) programs to comply with federally created obligations.[13] Although it is difficult to estimate the cost of complying with the Act, as construed by the Court below, it seems certain that the intial capital costs and the ongoing direct care, medical and programming costs will be monumental, especially when compared to the costs on the states of the minimum wage legislation struck down in *National League of Cities*.

Finally, the federal interest is ambiguous, but clearly insubstantial, when balanced against the extensive interference with traditional state functions. First, only a small proportion, approximately one percent, of all funds available for the care of the developmentally disabled are provided under the Act, H.R. Rep. No. 94-58, 94th Cong. 1st Sess., p. 6, (1975), *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 919, 924. Given the limited funding available under the Act; the purpose of the program is to promote ". . . effective planning by the states of their programs, initiation of new needed programs, and filling the gaps among existing efforts." *Id.* Second, the Act, as construed by the Court below, would conflict with the federal

whether or not they will be provided. *Quern v. Mandley*, 436 U.S. 725 (1978); *Beal v. Doe*, 432 U.S. 438 (1977); *Roe v. Norton*, 552 F.2d 928 (2nd. Cir), *on demand*, 408 F. Supp. 660 (D. Conn. 1975) (3-judge Court) *rev'd. sub nom Maher v. Roe*, 432 U.S. 464 (1977).

According to the Court below, however, the Act is not a grant program but is, instead, a mandate implementing the Fourteenth Amendment. The states, therefore, could not avoid the dictates of the Act by withdrawing from the program. 612 F.2d at 98, 99.

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[13]Even the administration of developmental disability programs will be subject to constant federal judicial scrutiny in that the judgment of the responsible state officials as to the "least restrictive alternative" may be challenged by the disabled citizen. Indeed, the Order of the Court below appointed a special master to make the individual determinations of the least restrictive alternative and to supervise the transfer of resident to the community. 612 F.2d at 114.

program which has the largest impact on the states delivery of services to the retarded in that large state schools for the retarded (or units within the institutions) have commonly met federal standards for reimbursement under the Title XIX medicaid program. Third, the legislative history of the Act is devoid of any indication, which would have been present, of any indication that Congress intended to impose massive new duties on the states without providing the funding to meet the newly created federal obligations (discussed *infra*). Fourth, although there has been a *recent* trend towards community services, the superiority of community services over more traditional approaches has not been established within the profession. Bella, *Relationship of Institution Size to Quality of Care: A Review of the Literature*, 81 Amer. J. of Mental Deficiency 117 (1976). Indeed, it is the opinion of the professionals in the Connecticut Department of Mental Retardation that an institution (adequately staffed and competently managed) remains the most appropriate placement for many of Connecticut's severely retarded and multiply handicapped citizen (discussed *supra*).

Wherefore, the Act, as construed by the Court below, impermissibly interferes with traditional state functions in violation of the Tenth Amendment to the United States Constitution.

II. The Act Does Not Provide the Developmentally Disabled With a Legal Entitlement to Treatment Which Must Be Rendered in the Least Restrictive Environment.

A.

The Act does not provide the developmentally disabled with a legal entitlement to treatment.

The difficult constitutional issues, discussed *supra*, are presented due to the construction of the Act by the Court

below, holding that the Act entitles every developmentally disabled person to treatment which must be provided in the least restrictive manner. While the Bill of Rights section, 42 U.S.C. §6010, is ambiguous, the construction by the Court below is inconsistent with the history of the Act, the legislative history of the 1975 Amendments and implementing HEW regulations.

Federal involvement in the area commenced with the Mental Retardation Facilities and Mental Health Centers Construction Act of 1963, P.L. 88-164, 77 Stat. 282 (1963), which provided grants to the states for construction of mental retardation facilities. House Rep. No. 94-58, *supra*, p. 2, 4, *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 919, 920, 922. The Act was substantially amended and renamed by the Developmental Disabilities Services and Facilities Construction Amendments, P.L. 91-517, 84 Stat. 1316 (1970), which broadened the scope of the Act from the retarded to the developmentally disabled generally and which authorized formula grants to the states for planning, administration and services in addition to the previously authorized grants for construction. House Rep. No. 94-58, *supra*, p. 4, *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 919, 922. The act was subsequently amended and renamed the Developmentally Disabled Assistance and Bill of Rights Act, P.L. 94-103, 89 Stat. 486 (1975) and further refined by the Developmental Disabilities Act Amendments of 1978, P.L. 95-602.

The Act provides grants to states electing to participate in the program. 42 U.S.C. §6063. Only a small percentage, approximately one percent, of all funds available from federal, state and local sources for services to the developmentally disabled are provided under the Act. House Rep. No. 94-58, *supra*, p. 6, *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 919, 924; H.R. Rep. No. 95-1188, 95th Cong. 2nd Sess., p. 51 (1978), *reprinted in* 6 (1978) U.S. Code Cong. and Ad. News 7355, 7359.

A state seeking funds under the Act must have a plan approved by the Secretary of Health, Education and Welfare, 42 U.S.C. §6063(b). The conditions of compliance are general with the participating states given broad administrative discretion within priorities established by Congress. 42 U.S.C. §6063 (b)(4)(B)(1979 Sup.).

Given the limited funding available under the Act, the purpose of the program is to promote "... effective planning by the states of their programs, initiation of new needed programs, and filling of gaps among existing efforts." House Rep. No. 94-58, *supra*, p. 6 *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 919, 924. Accordingly, those conditions of participation relating to the rendition of services apply only to programs receiving funds under the Act. For example, "services furnished . . . *under the plan*" and facilities in which they are provided must meet regulatory standards prscribed by HEW. 42 U.S.C. §6063(b)(5)(A)(i), and buildings "*used in conjunction* with the delivery of services *assisted under the plan*" must meet the requirements of the Architectural Barriers Act of 1968. 42 U.S.C. §6063(b)(5)(A)(ii). (Emphasis added).

The Developmentally Disabled Assistance and Bill of Rights Act of 1975 added for the first time the requirements of comprehensive evaluation systems, P.L. 94-103, Title II, 201, 42 U.S.C. §6009, 89 Stat. 502, and of individual habilitation plans, P.L. 94-103, Title II, §202, 89 Stat. 503, 42 U.S.C. §6011, and made "Congressional findings" respecting the rights of the developmentally disabled. P.L. 94-103, Title II, §201, 89 Stat. 502, 42 U.S.C. §6010.

In each case, the Senate Bill contained provisions placing onerous duties on the states which the joint conference refused to adopt.[14] Specifically, the Senate Bill, S. 462, contained a

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[14]See also S. 3378, 93rd Cong., 2nd Sess. (1974), and its Senate Report, Sen. 93-1169, 93rd Cong., 2nd Sess. (1974), *reprinted in* 13057-8 Sen. Miscellaneous Rep., Cal. No. 1117. The provisions of S. 462 were substantially identical to S. 3378 which passed the Senate one year previously, but died when the House failed to take it up.

requirement for an evaluation system for all services rendered to the developmentally disabled, but the conference compromise only requires a system ". . . for the evaluation of services provided to persons with developmental disabilities through programs assisted under the Act." H.R. Conf. Rep. No. 94-473, *supra*, p. 37, *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 943, 957; 42 U.S.C. §6009. And S. 462 provided that individual habilitation plans be maintained for every individual receiving services from all programs that receive any form of federal assistance, but the conference only agreed to require that a habilitation plan be required when funds under the DD Act ". . . contribute(s) a portion of the cost, of the habilitation services to the developmentally disabled person." H.R. Conf. Rep. No. 94-473, *supra*, p. 43, *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 943, 963; 42 U.S.C. §6011.

> "If, for example, the only Federal assistance received by a program is used solely to purchase a bus to transport developmentally disabled persons, then a written habilitation plan would not be required. If, on the other hand, a program to provide habilitation services to developmentally disabled individuals is supported in whole or in part by Federal funds under this Act, a written habilitation plan would be required for each program participant."
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> H.R. Conf. Rep. No. 94-473, *supra*, p. 43, reprinted in 2 (1975) U.S. Code Cong. and Ad. News 943, 963.

Finally the Senate Bill, but not the House Bill, contained detailed standards for the operation of all programs serving the developmentally disabled. The conference refused to adopt the standards and, as a compromise, made "Congressional findings" of a "right to treatment" which "should be" in the least

restrictive environment.[15] H.R. Conf. Rep. No. 94-473, *supra*, p. 41, 42, *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 961: 42 U.S.C. §6010 (1)(2).

Although Congress made a "finding" of a "right to treatment", Congress nowhere obligates the states to render treatment to its disabled citizens. It has merely been assumed that the states have an obligation to fulfill the "right to treatment," presumably because the states traditionally have provided such services in their role as *parens patriae*. It just as easily follows, however, that any right provided by 42 U.S.C. §6010(1) or (2) is enforceable against the federal governement in this "co-operative" program of providing services to the handicapped.

Furthermore the Act explicitly limits the obligations of the states under the Act. For example, Congress did provide that when a state provides residential services, the services must meet specified minimal requirements which are roughly analagous to conditions that raise Eight Amendment issues of cruel and unusual punishment. 42 U.S.C. §6010(3). And most significantly, Congress explicitly limited the obligations of the states to protecting the human rights of those retarded citizens who receive services funded by the DD Act.

> "(C) The plan must contain . . . assurances . . . that the *human rights* of all persons with developmental disabilities . . who are receiving treatment, services or habilitation *under programs assisted under this chapter will be protected consistent with section 6010* of this title (relating to the rights of the developmentally disabled)."
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> 42 U.S.C. §6063(b)(5)(C). (emphasis added)

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[15]The precatory language "should be" is inconsistent with the finding of the Court below of a mandatory duty to render services in the least restrictive manner, discussed *infra*.

In accord, the agency charged with enforcement of the Act (HEW) has issued regulations requiring only that the states ensure that those who receive services funded by the Act be provided with their human rights and be treated in accordance with individual habilitation plans. 45 C.F.R. §1386.1 (b)(5)(vi); 45 C.F.R. §1386.1 (b)(5)(x).[16]

Wherefore, the Court below erred by equating the states' obligations under the Act with Congressional "findings" of a "right to treatment" and in not recognizing that the declaration of Congressional findings is a statement of what Congress finds to be desirable, but is not a grant of a legal entitlement *vis a vis* the states.

B.

The Act does not obligate the states to render services in the least restrictive manner.

As noted, *supra*, the Court below held that the developmentally disabled have a "right to treatment" which is to be provided in the "least restrictive" manner. The source of the "right" to be treated in the least restrictive manner is 42 U.S.C. §6010(2) which provides that:

> "The treatment, services, and habilitation for a person with developmental disabilities *should be* designed to maximize the developmental potential of the person and *should be* provided in the setting that is least restrictive of the person's personal liberty." (emphasis added)

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[16]Curiously, the Court below never mentions the limitations of 42 U.S.C. §6063(b)(5) and 45 C.F.R. §1386.1(b)(vi). Indeed at 612 F.2d 96, the Court notes that, "(m)ore over, the revised statute contains a section requiring states to conform their plans to the dictates of the Bill of rights provision. Section 6010," but fails to note that the requirement is limited to assistance furnished under the Act.

The language of the statute uses the precatory language, "should be," in describing the desired treatment setting. Such language is inconsistent with the Court's finding of a mandatory duty to provide services in a prescribed manner.

The legislative history to the 1975 Amendments is in accord with the Conference Report again using the precatory language "should be" in describing the desired treatment setting. H.R. Conf. Rep. No,. 94-473, *supra*, p. 42, *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 943, 961.

The 1975 amendments did encourage deinstitutionalization by requiring that specified percentages of the States' allotments be spent on eliminating *inappropriate* placement in institutions. P.L. 94-103, *formerly codified at* 42 U.S.C. §6062(a)(4). Again the legislative history of the Act clearly indicates that the funding requirement was only intended to encourage a trend toward community based treatment.

> ". . . the Committee has chosen to include a specific requirement that state programs plan for as much deinstitutionalization as is feasible, and earmark monies for this purpose . . . It is anticipated that these requirements will prompt *some movement* of patients from State institutions back into their communities." H.R. Rep. No. 94-58, *supra*, p. 10, *reprinted in* 2 (1975) U.S. Code Cong. and Ad. News 919, 928. (emphasis added)

Significantly, the requirement that the states earmark funds for deinstitutionalization was deleted by the 1978 amendments which now require that states devote sixty-five percent of the funds received under the Act to any one of four specified priority areas of service, one of which is community based services, 42 U.S.C. §6063(b)(4)(A) (1979 Supp.), P.L. 95-602, 92 Stat. 3010. See generally H.R. Rep. No. 95-1188, *supra*, p. 2, 10, *reprinted in* 6 (1978) U.S. Code Cong. and Ad. News 7355, 7356, 7364.

The Court below reached its conclusion by recognizing a Congressional *preference* for deinstitutionalization; that "until 1978" state plans were required to contain a plan for the elimination of inappropriate placements in institutions and to "support the establishment of community programs as alternatives". 612 F. 2d at 104. The Court further cites the remarks of Congressmen Carter and Biaggi which indicate a preference for deinstitutionalization. From these expressions of *preferences* for deinstitutionalization, the Third Circuit found a right to treatment in the least restrictive manner. 612 F. 2d at 104, 105.

It should be noted that the Third Circuit, in finding a preference for deinstitutionalization, relied in large part on statutory provisions that had been repealed by the 1978 amendments, effective one and one-half years before its recent decision. As discussed, *supra*, the states must now devote the majority of its effort under the Act in any one of four areas of priority, one of which is community services. 42 U.S.C. §6063(b)(4)(B)(i). (1979 Supp.)

Well established rules of construction have developed concerning co-operative federal grant programs wherein Courts have consistently refused to require states to provide all services that are authorized or appropriate, but, instead, have recognized the states' rights to tailor their plans according to fiscal requirements and local preferences as long as the state plans met those requirements mandated by federal law. *Beal v. Doe, supra; Queen v. Mandley, supra; Roe v. Norton, supra.*

As pointed out by the dissenting opinion, the Court below elevated a preference for least restrictive treatment into a mandatory duty, without statutory authority to do so.

> "The duty of the states under the Act is to provide alternative individual habilitation to the extent feasible, which includes a wide variety of fiscal concerns. Yet the impact of the approach taken by the majority

> is exactly the opposite: it imposes a duty to provide less restrictive treatment regardless of cost or available funds . . . It is improper to say an implied cause of action exists and then impose new substantive duties nowhere present in the statute in question."
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> *Halderman v. Pennhurst*, 612 F. 2d at 119 (dissenting opinion).

Significantly, in the only decision, subsequent to the one of the Court below, of which this *amicus* is aware, the Court refused to adopt the reasoning of the Court below but held that ". . . there is no section in the DDA which mandates deinstitutionalization, *per se*," and that "Congress still left it to the states to decide the proper allocation of funds and did not authorize federal courts to dictate how those funds were to be spent by the states." *Kentucky Ass'n for Retarded Citizens v. Conn., No. C78-0157 (A) (N.D. Ken. March 21, 1980) slip op.* p. 20. *Kentucky Ass'n for Retarded Citizens* reasoned that:

> "When paragraphs (1), (2) and (3) of 42 U.S.C. Sec. 6010 are fully examined, it seems fair to state that Congress contemplated that institutional as well as residential programs for the handicapped would continue to be provided, and, further, that the programs which are provided must either provide appropriate treatment and habilitation or meet the six standards referred to in paragraphs (3)(B)(i) through (vi).
>
> Read in this manner, it is far from apparent that Congress was mandating the discontinuance of institutional programs. On the contrary, it would seem that Congress realized that there might even be situations where a developmentally disabled person would not have to be furnished treatment and habilitation as such, but would have to be provided with custodial care according to minimum standards such

as proper diet, appropriate medical services, proper safety compliance, and prohibition of the use of physical restraint."

Kentucky Ass'n for Retarded Citizens v. Conn., *supra*, p. 19, 20.

Finally, the minimal federal finding belies federal intent to require that the states always provide treatment in the least restrictive alternative in this "co-operative" federal grant program. See *Quern v. Madley*, *supra*, p. 745, 746.

CONCLUSION

The decision of the Court below should be reversed.

Respectfully submitted,

THE STATE OF CONNECTICUT

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Supreme Court of the United States

October Term, 1980

Nos. 79-1404, 79-1408, 79-1415, 79-1489

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,
Petitioners,

v.

TERRI LEE HALDERMAN, et al.,
PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS, et al., and
UNITED STATES OF AMERICA
Respondents.

On Writ of Certiorari To The United States Court of Appeals for the Third Circuit

BRIEF FOR THE CONNECTICUT ASSOCIATION FOR RETARDED CITIZENS, INC. THE STATE OF CONNECTICUT OFFICE OF PROTECTION AND ADVOCACY FOR HANDICAPPED AND DEVELOPMENTALLY DISABLED PERSONS, et al. AMICI CURIAE

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BRIEF FOR THE CONNECTICUT ASSOCIATION FOR RETARDED CITIZENS, INC., THE STATE OF CONNECTICUT OFFICE OF PROTECTION AND ADVOCACY FOR HANDICAPPED AND DEVELOPMENTALLY DISABLED PERSONS, et al. AMICI CURIAE

INTEREST OF THE AMICI

The Attorney General of Connecticut, purporting to represent the interests of this state, argues in his brief that the decision below will interfere with Connecticut's method of caring for its retarded citizens and that it will impose a financial burden on its taxpayers. The Attorney General does not express the views of the disabled citizens of this State and the principal organizations that serve them. *Amici* (whose interests are described more fully below) believe that it is important that the Court understand that the system of care the Attorney General would preserve is little more than a series of large, impersonal and dehumanizing institutions, the long term operation of which is inconsistent with state policy adopted by the Commissioner of Connecticut's Office of Mental Retardation in 1973. *Amici* contend that Connecticut's reliance on outmoded institutions is not only harmful for the persons consigned there, but also promotes the breakdown of family ties, and increases stress on the family unit. *Amici* also contend that the Attorney General's unsupported claim that a community service delivery system for retarded persons is too expensive is simply untrue. *Amici* believe that the decision below must be sustained so that public officials can be required to implement the policy that was adopted by Connecticut in 1973 — that *all* retarded people should live among their fellow human beings rather than in isolated institutions.

1. The Connecticut Association For Retarded Citizens, Inc. [CARC] is a private non-profit corporation created under Connecticut's laws in 1951, has twenty-five member chapters and a membership of 9,100 persons statewide. The purposes of the organization are to promote the general welfare and protect the rights of Connecticut's retarded citizens. Its membership includes parents, other relatives, guardians, and friends of retarded persons and retarded people themselves who live at home or in Connecticut's two large dehumanizing institutions — the Mansfield and Southbury Training Schools. For twenty-nine years CARC and its member chapters have conducted programs for retarded persons and acted as advocates for them. In the face of the exclusion of retarded persons from generic services, these parents joined together, originally, to create and operate community-based services through their association, and then to secure passage of legislation to mandate provision of such services and more recently, to enforce the duties of responsible public agencies to provide community-based educational, residential, vocational, recreational and other opportunities for retarded people so that they can live among rather than separate from their fellow human beings.

2. The State of Connecticut Office of Protection and Advocacy for Handicapped and Developmentally Disabled Persons was established pursuant to 42 U.S.C. § 6012 and Connecticut General Statutes § 46a-10. Its Director of Advocacy, Eliot Dober, was appointed by Governor Ella Grasso and is empowered to act as an advocate for handicapped persons and to initiate and fund legal actions to protect their rights. Mr. Dober has become increasingly concerned about programs of state officials which have resulted in indefinite placement of disabled persons in nursing homes and institutions for which the sole articulated justification is the unavailability of appropriately structured community settings.

3. The Connecticut Coordinating Committee of the Handicapped, Inc. (CCCH) is a statewide, consumer-oriented, private, non-profit corporation created under the laws of Connecticut in 1977. Its principal objective is the achievement of equal opportunity for the state's disabled citizens in all phases of their lives: housing, employment, recreation, transportation, and education. The CCCH is particularly concerned about arbitrary requirements placed on Connecticut's public assistance and service programs for handicapped persons which force such a large percentage of Connecticut's disabled citizens into nursing homes, institutions and similarly inappropriate facilities where their opportunity to participate in and enjoy normal activities is substantially curtailed.

4. The Mental Health Association of Connecticut, Inc. is a private, non-profit corporation founded under the laws of Connecticut in 1908, and has 900 members statewide. The purposes of the Association are to educate the general public on matters of concern to persons with mental disabilities, to protect the rights of mentally handicapped citizens, and to secure passage of laws providing for the development of community services in order to advance its goals of care and treatment in the least restrictive environment. The Association is particularly concerned about the inadequacies in Connecticut's institutions for disabled people and the state's policy of dumping hundreds of residents from state institutions into nursing homes which are unable to respond to the needs of mentally handicapped people.

5. The Connecticut Citizens Concerned with Convalescent Care is a coalition of individuals and agencies concerned with adequate care and the rights of elderly and handicapped persons living in Connecticut's nursing homes. The Coalition was formed in 1979 by the Gray Panthers, the Coalition on Aging, the Area Council on Aging of the State Department on Aging, the Mental Health Association of Connecticut, Connecticut Legal Services, Inc. and the

Connecticut Association for Retarded Citizens, Inc. The purposes of the Coalition are to advocate for individual residents of nursing homes and to secure passage of laws that insure appropriate care and treatment for these residents and protect their rights.

6. The Low Income Planning Agency, Inc., is a private, non-profit corporation established in 1974 to encourage, promote and stimulate the development of community resources with a particular interest in securing human rights established and guaranteed by law regardless of race, color, religion, creed, age, marital status, national origin, sex, mental retardation or physical disability. Governed by a Board of Directors, fifty-one percent of whom are low-income persons from communities throughout Connecticut, the Agency favors deinstitutionalization and the development of community-based services for handicapped persons, believing that these persons, their families, and the community at large benefit from the fullest possible development of the human resources of all of its citizens.

SUMMARY OF ARGUMENT

Connecticut has filed a brief supporting Pennsylvania's position that the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000 *et seq.* (hereinafter cited as DD Act), does not support judicial orders providing relief to retarded persons subjected to a harmful institutional environment. This responding brief sets forth the views of Connecticut organizations that serve disabled persons and of disabled citizens themselves.

The arguments advanced by the State of Connecticut in its brief are in sharp conflict with the position taken by the State of Connecticut in 1973 in *Project "Challenge", The Long Range Plan of the Office of Mental Retardation* by the Commissioner of Connecticut's Department of Mental Retardation, then, as now, Gareth Thorne:

> There is no simple answer to planning a future for more than 45,000 mentally retarded people in Connecticut; but the courts of the land, and the people who have given great thought to this issue — not only the parents but the professionals as well, have strongly indicated and pressured a course of action which ensures the rights of the mentally handicapped person to live in partnership with his fellow beings. To make any other decision would be to turn away from this central issue and to thereby seek expedient means for avoiding a major social and legal responsibility. One of the greatest temptations that society faces is to treat only the symptoms of the major problems brought about by society's failure in the past to deal properly with the problem of the mentally handicapped. The symptoms that are so frequently dealt with relate to the conditions found in the majority of the institutions in the United States and the temptation to somehow with a few dollars patch these facilities up, or in some instances to rebuild them as continuing warehouses of human beings. The problem basically is that outmoded institutions exist, and every effort must be made to resolve this problem

> and to prevent it from occurring again by literally tearing outmoded facilities down brick by brick until nothing remains, and in this process bring the handicapped person back home to the community where he belongs.[1]

Project "Challenge", The Long Range Plan of the Office of Mental Retardation, 1 (1973).

These views were set out in a 1973 planning document, *Project "Challenge",* that called for the development of small home-like community settings and community support systems to accommodate Connecticut's retarded citizens to make their continued institutionalization unnecessary. Two years later the Congress also reached the conclusion that the consignment of retarded persons to isolated institutions was harmful, and in the Bill of Rights provisions of the DD Act, 42 U.S.C. § 6010, required that it be ended in the same way. It is precisely because Connecticut has not implemented this policy and, in the process, eliminated the tragic warehousing of human beings in this state that the disabled citizens of this state and the organizations that serve them argue below that the Third Circuit Court of Appeals decision in *Halderman* v. *Pennhurst,* 612 F. 2d 84 (3rd Cir. 1979) must be affirmed.[2]

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[1]The Commissioner of Mental Retardation apparently has strong reservations about representations made in Connecticut's brief. In a public statement dated September 22, 1980 marked by the Commissioner for wide distribution he said:

> "I wish to make it perfectly clear that the Commissioner of the Connecticut Department of Mental Retardation did not file a brief nor did he participate in the preparation of the brief by the Attorney General's office."

[2]Two of these organizations, the Connecticut Association for Retarded Citizens and the State of Connecticut Office of Protection and Advocacy for Handicapped and Developmentally Disabled Persons, together with families with retarded members and disabled residents of the Mansfield Training School and equally inappropriate nursing homes have also initiated litigation to end the harmful consignment of retarded persons to those institutions. *See, Connecticut Association for Retarded Citizens v. Gareth Thorne,* No. H78-653 (D. Conn., filed Dec. 6, 1978).

ARGUMENT

1. THE FAILURE OF INSTITUTIONS IN CONNECTICUT

Connecticut's first institution for retarded people was established in 1858 to educate individuals who, because of their handicapping conditions, were unable to effectively use community-based educational facilities.[3] That institution, the Connecticut School for Imbeciles at Lakeville, Connecticut, grew from an educational facility with fifteen students in 1858 to a facility with 304 residents in 1915. Then, in the midst of the eugenics scare, the Connecticut Legislature appropriated $200,000 to expand and consolidate the School for Imbeciles with the Connecticut Colony for Epileptics at a new facility in Mansfield, Connecticut today called the Mansfield Training School. The superintendent of the School for Imbeciles explained the purpose of this expansion as follows:

> Stop the supply of the vicious, the weak, the no-willed people who cannot support themselves in the community — of the criminals and prostitutes and paupers, by cutting off the supply at its source, namely — by

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[3] *Report of the Commissioners on Idiocy*, 17 (1856) (On file at the Connecticut State Library).

On January 4, 1974, the Director of Administrative Services of Connecticut's Office of Mental Retardation, describing the Connecticut Community Residence Program, said:

> The past five years have seen the intensification of a national effort to move retarded individuals from institutions to a variety of community settings. Community placement has become the major mental retardation program in many states. In view of this "new" thrust, it is of interest to note that over 100 years ago — in 1866 — S.G. Howe wrote, "In organizing a new institution there should be built only a building for school rooms, music rooms, and workshops; and these should be in or near the center of a dense population. For other purposes, ordinary houses would suffice."

DuBrow, The Connecticut Community Residence Program (January 4, 1974).

> providing adequate custodial care for the feeble minded of the State. This is especially important in the case of women of child-bearing age. Admission to the Lakeville School has been sought for many of this class during the past year, but there was no room for them. *The Menace of the Feeble-Minded At Large in Connecticut*, 9 (1915) (On file at The Connecticut State Library).

These official efforts to separate retarded persons from society, and the concomitant failure to provide any services for retarded people in the community, led to such rapid growth in the size of the Mansfield facility that by 1934 it housed 1159 inmates and had a waiting list of 1073.[4]

This increased demand for services of some kind, it was thought, necessitated a second institution for retarded persons at Southbury, Connecticut, which opened in 1941. The Southbury Training School was intended to be an educational facility that would train and *return its residents promptly to community settings.* Yale Professor of Psychology, Dr. Seymour Sarason, has described the failure of that stated purpose at Southbury:

> [T]he Southbury Training School was for some time an international showcase because of its striking architectural features, country setting, commitment to being an educational rather than a custodial setting, and its objective of returning its residents as quickly as possible to the community. . . . The educational emphasis was a response to the fact that Southbury had been built to take care of the waiting list of the other and much older training school. Needless to say, things did not work out as they were supposed to, and it was not long before Southbury had its own waiting list and had settled into familiar institutional traditions.

S. Sarason and J. Doris, *Educational Handicap, Public Policy, and Social History*, 85 (1979).

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[4] *Biennial Report of the Mansfield State Training School and Hospital*, (1934) (On file at the Connecticut State Library).

The failure of Southbury Training School led parents and professionals alike to the conclusion that institutions had not responded to either the needs of their residents or to the complex needs of families with handicapped children.

> Far from being possible vehicles for solving problems, these institutions are the problem. They reflect and perpetuate the segregation mentality, the major consequence of which is the erection of barriers between the community and the institution. These institutions are like ghettos; over time those within and without feel comfortable staying apart, colluding, so to speak, in the fiction that this is the best and most "natural" state of affairs. Until, of course, the scandals and exposes destroy the fiction.

S. Sarason and J. Doris, *Educational Handicap, Public Policy, and Social History,* 93 (1979).

The pattern was all too familiar. A family kept its retarded member at home despite enormous pressure without professional guidance as to how to manage and extinguish negative behaviors, without respite care, and without the necessary vocational and other community day programs until the family disintegrated or made the only other available decision (which did little to alleviate the strain on the family) — put its retarded family member in an institution. The stress caused by the necessity of providing constant care for a handicapped child at home was then replaced with the new and often more devastating stress created among family members who felt failure and guilt about permanently placing a family member so far away in a dehumanizing institution.[5]

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[5]Connecticut's Commissioner of Retardation, in a letter dated December 15, 1977 to Mr. Gene Broumas, President's Commission on Mental Health,has accurately expressed the devastating effect institutionalization can have on the retarded person as well:

> Lack of a full array of the services described above had led to an historical situation whereby large numbers of developmentally disabled children have been placed into an institutional environment which has exacerbated their handicap by excluding

2. THE REGIONAL CENTER SYSTEM — AN OPPORTUNITY LOST

In 1959 Governor Abraham Ribicoff, other public officials and parents concluded that families with retarded members could best be helped not by creating another institution or by fixing up the old ones but by setting up a community service network to support families so that they could remain an integral part of the active treatment process and be included as a vital force in the disabled person's life. To this end they agreed to develop twelve regional centers, the primary purpose of which would be to support and assist families and disabled people in the community so as to make institutionalization unnecessary. It was evident to professionals who set up the regional center system in 1960 that indeed institutions were unnecessary:

> We quickly found that individuals on the emergency waiting list were there not because they required institutional care but because a variety of community services and programs (such as group homes, homemaker services, parent education and counseling, baby-sitting help, marital counseling) were not available or, if available, were unknown to the family. Some of these families were requesting institutionalization because they had been told that it was the best course of action, and not because they personally desired it. There was not a single case, regardless of severity, for which an alternative to institutionalization was not possible, if community resources, actual and potential, could be utilized. . . . What struck us forcefully was that these alternatives would *create* fewer major social problems than institutionalization would (or has). Indeed, in the

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emotional spontaneity and individual attention and love from their lives. As a result, there are few institutionalized mentally retarded persons who do not have at least some degree of emotional disturbance which become an additional barrier to their reaching their potential.

> process of developing some of these alternatives we found many people in the community grateful for the opportunity to be helpful, to be part of something that brought new knowledge and challenge into their lives...
> . . . .
>
> These were exciting months for everyone . . . . If the millions that were going into buildings were made available to us we could develop scores of programs and settings in and by the community, and in many ways would bring new meaning into the lives of many people.

S. Sarason and J. Doris, *Educational Handicap, Public Policy, and Social History,* 87, 88 (1979).

As a result of the Kennedy initatives[6] and the several acts of Congress[7] during the 1960's, Connecticut extended its regional center system throughout the state. Administrative offices with professional staff opened in each of the twelve regions to assist families and develop and coordinate services. Legislation was enacted authorizing state grants to

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[6]In 1963 President John F. Kennedy asked the Congress to enact legislation:

> To retain in and return to the community the . . . mentally retarded, and there to restore and revitalize their lives through better health programs and strengthened educational and rehabilitation services; and
>
> To reinforce the will and capacity of our communities to meet these problems in order that the communities, in turn, can reinforce the will and capacity of the individual and individual families.

109 *Cong. Rec.* 1842 (1963).

[7]*See,* The Maternal and Child Health and Mental Retardation Planning Amendments of 1963, P.L. 88-156, 77 Stat. 273 (1963); The Mental Retardation Facilities and Community Mental Health Center Construction Act of 1963, P.L. 88-164, 77 Stat. 282 (1963); The Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965, P.L. 89-105, 79 Stat. 427 (1965); and The Developmental Disabilities Services and Facilities Construction Act of 1970, P.L. 91-517, 84 Stat. 1316, § 207 (1970).

private non-profit agencies providing day care, recreation, vocational training and sheltered workshop programs.[8] These developments culminated in 1973 with the adoption of the policy set out in the State's long range plan[9] that *all* retarded people should live among their fellow human beings rather than in isolated institutions.[10]

During this period Connecticut used federal funds under the Title XIX program[11] to develop community residential alternatives to accommodate some of the over 1000 retarded persons who were scheduled to be returned to the community from institutions. Governor Meskill announced that 100 group homes would be developed within two years, and, in fact, twenty-two were developed by 1975.

By the mid-1970's, after fifteen years of progress, Connecticut had in place a system which provided it with a unique opportunity to displace its institutions. Unfortunately, Connecticut in 1980 still has not acted on that opportunity. For example, aside from the development of a few apartments and foster homes, only three group homes

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[8]That legislation, originally codified as Connecticut General Statutes §§ 19-4d, 19-4e, and 19-4f, is now found at Connecticut General Statutes §§ 19-571, 19-572, and 19-573.

[9]The policy, found in the preamble of Connecticut's 1973 long range plan, is set out at page 5, *supra*.

[10]In 1974 the Director of Administrative Services of the Connecticut Office of Mental Retardation described the rationale behind its policy of returning retarded people to community settings as follows:

> Policy regarding the development and use of community residential programs for the retarded is based on the belief that for many, *regardless of the level of retardation,* a place to live in a community setting is essential to their growth and well-being as persons and citizens.

DuBrow, The Connecticut Community Residence Program, (January 4, 1974).

[11]The regulations implementing the 1971 amendments to Title XIX covering funding of two categories of intermediate care facilities for the mentally retarded are now codified at 42 C.F.R. Part 442.

have been opened by the state since 1975, and one has closed.

Connecticut soon identified another and more expedient method of reducing the size of its institutions. Contrary to the will of Congress[12] Connecticut began literally "dumping" hundreds of retarded persons into nursing homes[13] with patient populations as high as 500, and using then, as now, the excuse that overcrowding and deplorable

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[12]In 1971, Senator Bellmon, presenting an amendment to Title XIX to end inappropriate and expensive nursing home transfers like those subsequently undertaken by Connecticut, stated:

> Intermediate care was established because many thousands of assistance recipients were being classified as skilled nursing home patients even though they needed a lower level of care. That was done because federal matching funds were available for skilled nursing care but was not available for institutional care below that level. 117 *Cong. Rec.* 44720 (1971).

[13]Connecticut's Deputy Commissioner of the Department of Mental Retardation, in testimony before the State of Connecticut Commission on Hospitals and Health Care on August 2, 1979, stated:

> There have been in the past people who are profoundly or severely retarded who needed care but probably not quite the medical care or nursing care the SNF [Skilled Nursing Facility] requires or SNF provides.
>
> . . . .
>
> There are not enough of the appropriate number of beds for mentally retarded people in the state to provide safe and humane accommodations for them and until that exists we're going to have to continue to use skilled housing facilities in the community and to continue to overcrowd our existing facilities.

Connecticut's long range plan itself also supports this view:

> At the present time the Department of Mental Retardation has 736 clients placed in Skilled Nursing Facilities (SNF) in Connecticut. . . .
>
> At this printing, the evaluation has been completed on nearly 40% of the total SNF placements, and based on this sample it is estimated that approximately 300 individuals could be more appropriately served in another type facility. . . .

Project Challenge, 31 (1979)

conditions at the institutions justified large-scale transfers.[14] These transfers were a financial boon to the nursing home industry which, until then, had difficulty filling its facilities and resulted in a significant cost savings for the Department of Mental Retardation and for the State of Connecticut.[15]

Connecticut was apparently well aware that nursing homes were staffed to meet only medical needs of a very

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[14]The Commissioner of Mental Retardation of this state has characterized these occurrences as follows:

> Now, beginning the early seventies, because of staffing problems, because of inadequacy of buildings, three-story buildings at Mansfield, structures at Southbury that needed renovation, overcrowded, superintendents assessed the situation and recognized that the people in their facilities were not getting the 24-hour nursing care at the level that they felt was appropriate to the individual's needs and so, in order to reduce the overcrowding, in order to abandon some outmoded buildings and in order to enable renovations to take place and give the time for new construction of new regional facilities and so forth to occur, movements were made of those people that we felt were at risk in our situation to skilled nursing facilities where we felt they would be — receive more appropriate care than we could offer, recognizing it was institutional care and we never in any way described that as being [de] institutionalization, it was a lateral institutional move, and the plan being that — it was and still is. . . .
>
> That's still part of the process, so we're working with a backlog of a large — a waiting list, overcrowded institutional facilities, lack of other alternatives, we have been working at that certainly ever since I have been here . . .

Deposition of Gareth Thorne, taken on February 7, 1980 in *Dober* v. *Thorne,* No. H79-498, 40, 41 (D. Conn. filed August 31, 1979).

[15]Page 31 of the official planning document, *Project Challenge,* (1979) indicates that financial responsibility for persons transferred from state institutions into nursing homes rests with another state agency:

> These clients [those in SNF facilities] continue to be the responsibility of the Department, although the cost of their care is paid for by Title XIX through the Department of Income Maintenance.

limited (elderly and infirm) population.[16] Even so Connecticut chose to transfer retarded people whose primary needs are for educational and habilitative services. This wholesale "dumping" of retarded persons into facilities incapable of meeting their needs resulted in a tragic chapter in the care of Connecticut's handicapped citizens.[17] Current

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[16]The Health Systems Agency of North Central Connecticut at page 2 of its panel report of April 15, 1977 regarding the *Lorraine Manor Proposal to Convert Facility to Habilitative Nursing Facility* states:

> Ms. Toni Richardson, Director of the Division of Licensing of the Department of Mental Retardation, indicated that the license which would be awarded to Lorraine Manor would be for the severely and profoundly retarded patient with multiple handicaps who also has intense medical needs. Approximately 40 people have been identified in Connecticut who fall into this category. . . .

[17]Frequently the staff at such facilities are not familiar with and therefore cannot identify and respond to the developmental needs of retarded people. On January 16, 1979 the Director of the Division of Survey and Certification Operations of the United States Department of Health, Education and Welfare in a letter to the Connecticut Department of Health Services described the failure of two Hartford-area skilled nursing facilities to recognize and meet the developmental needs of their 200 retarded residents:

> During the brief time that I was in each of the facilities programmatic activities were at an absolute minimum. A feeding program was in process at Hillside Manor for three or four residents. It appeared that many more of the residents required similar training. Other program activities could not be observed because of the time of day I was in each facility. However, available staff did not appear to be adequate to provide any kind of ongoing program direction to improve the functioning levels of the residents. Furthermore, many residents were observed slouched down in wheelchairs and curled up in fetal positions throughout each facility. Staff did not appear to be aware of the importance of proper positioning to avoid the development and further aggravation of contractures.
>
> My observation based on a very limited walk through both of the facilities was consistent with the findings of the federal survey team which visited them early in the Fall.

state planning documents, however, contain no concrete plans to relocate this class of reinstitutionalized people to appropriate community living arrangements.

In 1975 in Section 6010 of the Developmentally Disabled Assistance and Bill of Rights Act, the Congress studied and addressed the chronic and continuing deficiencies that plagued the nation's institutions for retarded persons. The Chairman of the Senate Labor and Public Welfare Committee, during floor debate in the Senate, echoed the findings and concerns expressed by Connecticut's public officials in its 1973 long range plan:[18]

> Over the past few years, the horrifying conditions which exist in most of the public residential institutions for the mentally retarded . . . have provided shocking testimony to the inhuman way we care for such persons. The conditions at Willowbrook, at Partlow in Alabama, and at Rosewood in Maryland, and at many other institutions have shown beyond a shadow of a doubt that the treatment of these individuals is worse than all of us would like to admit.
>
> Steps to scale down many of these large custodial institutions have resulted in not-so-large institutions, often with not much improved care and with little follow-up. This has been true at Willowbrook: in 1965 and again in 1972, broad criticism has been levied at this institution; all indications point toward little change, unless substantial legal advocacy pressure is forthcoming. While much can be said about the lack of available funds to improve conditions at these institutions at some point this country must draw the line.

121 *Cong. Rec.* 16516-17 (1975).

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[18] *Compare* Statement taken from the 1973 Connecticut long range plan at page 5 *supra*.

The Congress concluded, just as had Connecticut officials two years earlier, that the problems presented by the existence of large-scale, isolated institutions could be remedied only by phasing them out and returning retarded people to communities among their fellow human beings.[19]

Connecticut argues that it does not want to be required to implement a public policy that requires it to provide minimally adequate habilitation in the least separate, most integrated community settings. Seven years have passed since the state itself formally adopted that very policy in its long range plan. Yet, community development remains at a standstill and families with handicapped members continue to disintegrate in the absence of community services until, in desperation, they request the only help available — a residential placement in a state institution.[20] Meanwhile, the residents at the Mansfield and Southbury Training Schools regress and deteriorate in the absence of an effective

---

[19]These findings of the Congress are:

> It must be recognized that the vast majority of developmentally disabled persons and the vast majority of persons now institutionalized should not be in these institutions at all. Efforts to assure proper treatment, education, and habilitation services in large institutions should not deflect attention from the fact that most of these institutions themselves are anachronisms, and that rapid steps should be taken to phase them out. Many of these institutions by their very nature, their size, their isolation, their impersonality, are unsuitable for treatment, education, and habilitation programs.

S Rep. 94-160, 94th Cong., 1st Sess. (1975) at 32, 33

[20]The urgent waiting list for a residential placement in this state now contains some three hundred names. An urgent case is defined at page 28 of the 1979 revision of *Project Challenge* as one where a residential placement is necessary to prevent major deterioration or dysfunctioning of the client or his family unit.

program[21] and suffer under inhumane conditions similar to

[21]On March 15, 1976 the President of *amicus curiae*, the Mansfield Parents Association, in a letter to Governor Ella Grasso, wrote:

> The lack of appropriations for personnel for the new cottages is not the only problem of "direct care" employee shortage. There has always been extreme "direct care" staff shortages throughout the institutional complex, including the hospital units.

Despite the expenditure of millions of federal Title XIX dollars ostensibly to meet minimum federal program standards, the Medicaid survey team which, in Connecticut, is housed within the Department of Mental Retardation, found in its survey report dated September 6, 1979 that the absence of program, especially among Mansfield Training School's most severely handicapped residents, is so pronounced that residents are literally warehoused:

> there is no time for the aides to spend in the development of clients' self-help skills. . . .
>
> . . . .
>
> All the multiple handicapped and non-ambulatory residents do not currently have planned daily activity and exercise periods nor have the clients been rendered mobile by methods or devices such as walkers, canes, etc. . . . .
>
> . . . .
>
> Every resident who does not eliminate appropriately and independently is not included in a toilet training program.
>
> . . . .
>
> Although clients who were incontinent were changed, they were changed on the bare floor with little consideration for privacy, comfort and sanitation.
>
> . . . .
>
> The clients are receiving only basic care with little programming to foster their development.

The Medicaid Survey Team also found during nine successive inspection tours of the best facilities at Mansfield Training School during the period October 18, 1978 through October 23, 1979 that professionals spend their time on paperwork rather than with clients, that direct care staff are inadequately trained to implement programs especially for the severely and profoundly retarded and that even those few clients that have written habilitation plans are not receiving the needed services.

The program at Southbury Training School is no better. At page 5 of the Annual Report for that facility for the period 1978-79, its superintendent said:

> "[L]iterally hundreds of Southbury residents have been penalized by admission since it is not possible to provide programs to meet their needs, especially those over 21 years of age."

those found at Pennhurst — conditions that cannot be tolerated in a free society.[22]

[22]On March 15, 1976, the President of *amicus curiae* Mansfield Parents Association, wrote about conditions at the Mansfield facility in a letter to Governor Ella Grasso:

> The Mansfield parents have a vested interest in the Training School and are duty bound and obligated to inform you of the unsafe and unhealthy conditions that continue to plague the institution because our bi-partisan political structure fails to care about their unfortunate and unproductive constituents.

Three years later the employees' union representatives from Mansfield Training School, in testimony before the Appropriations Committee of the Connecticut Legislature on February 27, 1979, indicated that essentially the same conditions still existed:

> Ms. Dubrino: Oh, the turnover rate at Mansfield is about 50% per year. We see people come in and work for one or two months and be totally discouraged with conditions that they leave and this does not provide a good continuity of services on the ward.

The inadequacies of Mansfield and its separation from the normal checks and balances of society have resulted in substantial and often unexplained casualties among residents. In each month during the period January, 1979 - April, 1979 at least twenty percent of the residents suffered injuries. In April of 1979, for example, 243 residents sustained 345 injuries including nine severe injuries — those resulting in fracture, hospitalization or death.

Similar longstanding problems plague the Southbury Training School. Since November of 1978, Connecticut's Medicaid Survey Team has found repeated widespread and improper use of chemical and physical restraints. The United States Department of Health and Human Services in a letter to Commissioner Thorne dated August 21, 1980, has expressed its deep concern over these problems:

> A recent review by the DMR's IPR/UR findings as well as the DMR's surveyor findings by personnel in my office indicated a long history of deficiencies in the areas of restraints, plans of care and medication review.
>
> . . . .
>
> The physical and psychological functioning of clients appeared impaired by the ongoing use of physical restraints . . . . the use of restraints, according to the team, in some instances, constitutes a health threatening practice for the client involved.
>
> . . . .
>
> This intervention, it appears, is little more than a "carte blanche" opportunity to utilize restraints as a substitute for activities and/or treatments.

The Third Circuit Court of Appeals decision in *Halderman* v. *Pennhurst* must be affirmed so that Connecticut can be held to the policy it articulated seven years ago, and so that the deplorable conditions at Connecticut's institutions can be remedied precisely as the Congress and officials of this state have concluded is necessary.

3. COMMUNITY LIVING IS NOT MORE COSTLY THAN INSTITUTIONALIZATION

Connecticut's *amicus* brief argues that placing retarded persons in properly structured community living arrangements will be more costly than keeping them in institutions. Thus, it argues, that implementation of the Third Circuit Court of Appeals decision constitutes significant federal interference into state affairs in violation of the Tenth Amendment to the United States Constitution. In particular, at page four of its brief, it asserts that:

> The Department's most recent calculations, however indicate that new construction costs an average of $37,322.42 per client bed, while purchased renovated group homes cost an average of $26,399.29 per client bed. Given the rapidly rising costs of moving a significant number of the three thousand (3,000) Connecticut citizens in the campus programs to community living arrangements would be well in excess of ninety million dollars (90,000,000.00).

Even if these cost figures are accepted, one does not have to look beyond Connecticut's own long range plan to see that the conclusion it would have this Court reach is inaccurate. *Project Challenge* lists as community-based alternatives to institutions: foster homes (community training homes), apartment living and group homes, none of which have to include capital outlay. Of the community beds now in place in this state, none involved new construction, and only a

small fraction were purchased and renovated.[23] Also, in addition to the foster care, apartment rental and leasing options set out in *Project Challenge*, community alternatives can be developed by contracting with private, non-profit or proprietary service providers. Again, all options involve no capital cost and are commonly used in other states. Such costs may also be covered by subsidies from the United States Department of Housing and Urban Development.

In support of its second argument that implementation of the Bill of Rights provisions of the DD Act as interpreted by the Third Circuit Court of Appeals will be costly, Connecticut argues that:

> [S]ignificant increases in annual operating costs will accrue due to the necessity of providing increased direct care staff and medical and psychological support services over a geographically diverse area.

Once again, we believe this assertion is misleading both because institutional care in this state is becoming extremely expensive[24] and because it ignores mounting evidence that community alternatives to institutional care are less costly.

Dr. Ronald Conley, expert witness for the plaintiffs in *Halderman v. Pennhurst* on the economics of services to mentally retarded people, argued as long ago as 1973 that small home-like community facilities for retarded people were cheaper than large isolated institutions. In support of this assertion he argued:

> (1) Because small facilities can be located in communities, it should be possible for them to obtain many services at a cost lower than would be incurred if the

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[23] *Project Challenge*, 12, 15-19 (1979)

[24] DMR has estimated in materials recently submitted to the Connecticut Commission on Hospitals and Health Care that annual institutional operating costs will exceed $60,000 for some residents by 1982. *Commission on Hospitals and Health Care Decision*, No. 79-545-S, 4 (1979).

> grams utilizing all community resources related to treatment or habilitation of such individuals to provide comprehensive services in the home community. *Id.* at 16520.

And Representative Tim Carter made clear that:

> We, as a committee, are well aware that treatment of the developmental (sic) disabled should be conducted in that person's community without unnecessarily institutionalizing him. *Id.* at 9976.

Undoubtedly Congress acted with premeditated consistency when it created the Bill of Rights and enacted it in conjunction with other funding and enforcement provisions. All were placed within one Act because all were seen as necessary for reforming those institutions which remained temporarily and for providing individualized "appropriate treatment" to all developmentally disabled persons regardless of treatment setting. Congress' "preference" for deinstitutionalization is pervasive throughout the Act, and clearly apparent in all significant parts. This "preference" ranges in its effect from that of mandatory right (§§ 6010(1) and (2)), to financially related conditions (§ 6010(3) and § 6011), planning requirement (§ 6063(b)), and general aspiration (§ 6000). Certainly the "preference" for deinstitutionalization was not intended to give participating states the unfettered right to continue the shameful overuse of substandard institutions.

C. *A Contrary Interpretation Would Create Absurd Results and Imply Futile Measures Enacted by Congress.*

The Act was the result of the failure and ineffectiveness of earlier funding statutes in eliminating the horrors of mental retardation institutions. It would be a cruel hoax to suggest that despite the addition of personal rights (§§ 6010(1) and (2)), funding conditions

(§§ 6010(3), 6011), planning requirements (§ 6063(b)), and advocacy mechanisms (§ 6012), Congress was once again enacting a mere funding statute. Congress did, in fact, explicitly call it a "Bill of Rights" Act, and rights were to be guaranteed. With respect to the 1978 Amendments, Senator Kennedy stated:

> Everyone in here knows that the only way that change is going to be brought about is the long, difficult, persistent, and dedicated advocacy of those who are prepared to follow through administrative hearings, through hearings on regulations, through challenges in the courts, for the kinds of rights which are being guaranteed in this legislation. That is the way it is done. [124 Cong. Rec. S15663 (daily ed. Sept. 21, 1978).]

Congress passed the Act not with the thought that the states would simply use federal dollars as they had done under past legislation, but with the requirement that specified rights would cease to be violated.

In order to conclude that the rights to treatment and treatment in the least restrictive setting (42 U.S.C. § 6010(1) and (2)) are not mandatory, one would have to believe that in 1978 Congress enacted the following portion of § 6010 as a totally meaningless provision: "The rights . . . described in findings made in this section are in addition to any constitutional or other rights otherwise afforded to all persons." It would be absurd for Congress to *state* that it had enacted viable rights in this section if it had in fact not done so. Such an interpretation would endorse an internal inconsistency in the section that would render implementation of the treatment "rights" an impossibility.

Furthermore, it would be nonsensical to presume that protection of rights under § 6010 was really only intended to cover specific programs actually receiving federal funds. Not only would such an interpretation clash

with the legislative history discussed in the previous section, but it would also mean that states which could not meet the requirements of the state plan would have no obligation to protect the fundamental rights Congress was addressing in the Bill of Rights. Only those states which met the conditions for approval of the plan would have to protect those rights. Thus the most recalcitrant states would be least bound to observe those core rights that on their face apply directly in favor of "persons with developmental disabilities," without restriction.

Even if one were to assume that such an illogical construction were correct, Pennsylvania would still be in violation of § 6063(b)(5)(C), a provision in the 1978 Amendments which makes the protection of rights under § 6010 a condition precedent to the receipt of funds under Title III for all "programs assisted under this chapter." That conclusion is compelled by the fact that Pennsylvania uses much of its federal funds under the Act to provide planning, public awareness and human rights projects which assist every program in the state's developmental disabilities system.

With regard to the use of federal funds it is also well settled by this Court that Congress "does have the power to fix the terms upon which its money allotments to states shall be disbursed." *Oklahoma* v. *Civil Service Commission* 330 U.S. 127, 143 (1947). In that case the Court ruled that state compliance with the Hatch Act was a permissible condition to the right to receive federal highway funds. Thus the Court upheld the removal from office of a member of the State Highway Commission found to have violated the Hatch Act. Surely the same result should attend the less onerous condition Pennsylvania has agreed to in this instance. Any other holding would collapse the entire structure and thrust of the Developmental Disabilities Act.

II. The Act May Be Enforced Under 42 U.S.C. § 1983.

In June, 1980, this Court ruled that individuals who have been deprived of "any rights, privileges, or immunities" provided for under a federal statute are entitled to bring a section 1983 cause of action, *Maine* v. *Thiboutot*, —— U.S. ——, 48 U.S.L.W. 4859, 4860 (June 25, 1980). The Court's decision, which arose under the Social Security Act, was broad enough to encompass the Developmental Disabilities Act. As this Court emphasized, "even were the language ambiguous . . . any doubt as to its meaning, has been resolved by our several cases suggesting, explicitly or implicitly, that the § 1983 remedy broadly encompasses violations of federal statutory as well as constitutional law." (*Id.* at 4860). It is noteworthy that in his dissent Justice Powell observed that the majority's decision would include a wide range of federal statutes. In an appendix he specifically lists the Developmental Disabilities Act (*Id.* at 4869, Part C, par. 12).

Only a couple of weeks before this Court decided *Maine* v. *Thiboutot*, the Southern District Court in West Virginia ruled that § 1983 could be used to enforce rights under a number of statutes which protect mentally retarded individuals including the Developmental Disabilties Act. *Medley* v. *Ginsberg*, No. 78-2099 CH (S.D. W.Va. June 10, 1980).

As has been shown above, both the terms and structure of the Act and its legislative history clearly demonstrate that the Act confers numerous "rights" upon developmentally disabled persons. These include the rights to appropriate treatment and habilitation (§ 6010 (1)) and to treatment in the least restrictive setting (§ 6010(2)). The Act also places specific conditions on the use of Act monies (§ 6010(3), institutional standards; § 6011, habilitation plans; and § 6063, state plan requirements), all of which are designed to cause direct benefits to run in favor of the developmentally disabled.

States wishing to participate in the program freely take on the general duty to provide treatment in the least restrictive setting, as well as the duty to comply with specific grant conditions once funds are received.

These rights are without question "of an essentially personal nature, touching such intimate things as living and eating conditions, freedom from the marks of modern peonage, work at starvation wage levels in degrading poverty." *See Gomez* v. *Florida State Employment Service*, 417 F.2d 569, 579 (5th Cir. 1969). While not labeled "civil" in the Act itself, these rights are intended to eliminate the discrimination against the mentally retarded that was typified by the institutional abuses noted by Congress. They are to be invoked by the mentally retarded themselves where they suffer direct personal harm.

Nothing in the history of § 1983 nor in its interpretation in *Maine* v. *Thiboutot*, *supra*, suggests that human rights, such as the right to treatment, should be less enforceable than statutory rights to money benefits. Indeed, a cause of action under § 1983 is a particularly appropriate means of enforcing these rights since it was realized by Congress that it was the action (or inaction) of state officials that resulted in the abuses mentally retarded people have suffered in the past. Such a cause of action could not unfairly intrude upon state activities since state activities concerning the developmentally disabled were the precise object of the Act as a whole.

Certainly no state that freely and intelligently entered into the cooperative program created by the Act could claim to be surprised to find that Congress wrote enforceable rights into its structure. The language of the Act and the legislative history are plain enough. Likewise, no state can offer objection to a private right of action under § 1983 since Congress was entirely open

when it stated that the right to appropriate treatment "should be protected and assured by the Congress and the courts." H.R. Conf. Rep. 94-473, 42 (1975), [1975] U.S. Code Cong. & Ad. News 943, 961.

A major component of the statutory scheme, of course, is the "protection and advocacy" system created by 42 U.S.C. § 6012, which Congress specifically stipulated must be able to pursue "legal, administrative, and other appropriate remedies" to protect the rights of the developmentally disabled. § 6012(a)(2)(A). A right of action under § 1983 is entirely consonant with the intent of Congress and would do no violence to the statutory program. *Cf. Chapman* v. *Houston Welfare Rights Organization*, 441 U.S. 600, 645, 672 (1979).

As the Court has so recently ruled in *Maine* v. *Thiboutot*, *supra*, the phrase "and laws" within § 1983 permits claims to be brought on violations of rights arising directly under federal statute. The federal Developmentally Disabled Assistance and Bill of Rights Act contains rights the deprivation of which must give rise to exactly this private cause of action.

CONCLUSION

For the reasons set forth above, the American Bar Association urges this Court to affirm the judgment and decree of the Court of Appeals.

Respectfully submitted,

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APPENDIX A

ABA House of Delegates—Policies Adopted August, 1978

COMMENDATION OF REPORT OF PRESIDENT'S COMMISSION ON MENTAL HEALTH

BE IT RESOLVED that the American Bar Association commends the Report of the President's Commission on Mental Health as an important and valuable study for consideration by officials and citizens concerned with improvement of the nation's mental health system; and

BE IT FURTHER RESOLVED that the American Bar Association endorses those recommendations of the President's Commission on Mental Health providing for protection of the human and legal rights of mentally disabled, i.e., the recommendations within the Report's section on "Protecting Basic Rights" which recommend that:

(1) All Federal agencies enforce existing laws and regulations which prohibit discrimination against mentally disabled persons and seek to equalize opportunities for such individuals.

(2) All Federal agencies review their statutes, regulations, and programs for instances of discrimination against mentally handicapped persons.

(3) The Department of Health, Education and Welfare vigorously implement the requirements of the Education for All Handicapped Children Act and formulate regulations to assist school districts to provide for the mental health needs of children and youth.

(4) Each state review its mental health laws and revise them, if necessary to ensure that they provide for:

a) a right to treatment/right to habilitation and to protection from harm for involuntarily confined mental patients and developmentally disabled individuals;

b) a right to treatment in the least restrictive setting;

c) a right to refuse treatment, with careful attention to the circumstances and procedures under which the right may be qualified; and

d) a right to due process when community placement is being considered.

(5) Each state have a "Bill of Rights" for all mentally disabled persons, wherever they reside.

(6) Mentally disabled persons in detention or correctional institutions should have access to appropriate mental health services on a voluntary basis and such access should not be connected with release considerations.

(7) All recipients of Federal funds to provide mental health services be required to adhere to certain basic principles of confidentiality, and that other institutions and facilities be encouraged to follow this practice.

(8) The establishment of advocacy systems for the representation of mentally disabled individuals. In adversary or judicial settings we recognize the importance of counsel to represent not only the mentally disabled client (or those acting in his or her behalf) but also the state or provider against which a claim is made.

(9) Each State review its civil commitment and guardianship laws and revise them, if necessary, to incorporate increased procedural protections.

APPENDIX B

ABA House of Delegates—Policy Adopted August, 1977

IMPLEMENTATION OF FEDERAL RIGHTS FOR THE MENTALLY HANDICAPPED

BE IT RESOLVED that the American Bar Association urges the swift and effective implementation of federal laws and regulations codifying the rights of mentally handicapped persons, and further urges state governments to consider legislation insuring such rights within their respective jurisdictions.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,
Petitioners,

v.

TERRI LEE HALDERMAN, et al.,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF *AMICI CURIAE* AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, NATIONAL ASSOCIATION OF SOCIAL WORKERS, MENTAL HEALTH ASSOCIATION, ASSOCIATION FOR RETARDED CITIZENS—CALIFORNIA, AMERICAN CIVIL LIBERTIES UNION, AND MENTAL HEALTH LAW PROJECT IN SUPPORT OF RESPONDENTS

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H.R. Rep. No. 95-1188, 95th Cong., 2d Sess. 9-10, *reprinted in* [1978] U.S. Code Cong. & Ad. News 7364	12
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Kaufman, *The Formation of a Learning Set in Institutionalized and Non-Institutionalized Mental Defectives*, 67 Am. J. Men. Def. 601 (1963) .. 8

Pennsylvania Developmental Disabilities Plan (1979) 19, 21, 22

Pennsylvania Developmental Disabilities Plan (1980) 21, 22

Rubin, *An Economic Analysis of Litigation and Legislation for the Handicapped*, in BUREAU OF ECONOMIC RESEARCH, DISABILITY AND HEALTH ECONOMICS RESEARCH (1976) 14

Sternlight & Siegel, *Institutional Residence and Intellectual Functioning*, 12 J. Men. Def. Res. 119 (1968) 8

Stimpson et al., *Effects of Early Institutionalization on Growth and Development of Young Children with Down's Syndrome*, 67 Mich. Med. 1213 (1968) 8

Wallick & Montalto, *Symbiosis or Domination: Rights and Remedies Under Grant Type Assistance Programs*, 46 Geo. W.L. Rev. 159 (1978) .. 16

INTEREST OF *AMICI CURIAE*

Amici curiae are organizations of mental retardation and mental health professionals, citizens and lawyers concerned with the legal rights of mentally retarded people to receive appropriate services.[1] *Amici* have in common a strong commitment to the provision of educational, residential, medical and social services to mentally

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[1] Henceforth in this brief, *amici* will include:

(1) The American Orthopsychiatric Association, an interdisciplinary organization of 4,000 members including psychiatrists, psychologists, social workers, educators and allied professionals concerned with the problems, causes and treatment of abnormal behavior;

(2) The National Association of Social Workers (NASW), with chapters in all 50 states and the District of Columbia; the largest professional association of social workers in the world. More than one-third of its 83,000 members are engaged in providing health and mental health care services in public, voluntary and private institutional and outpatient settings throughout the country. NASW is devoted to the establishment and maintenance of high standards of professional practice and to the advancement of sound public policy for consumers of social work services. Promotion of community-based alternatives to institutionalization and support for the legal rights of patients and residents of institutions are among NASW's priorities for the 1980s;

(3) The Mental Health Association, a citizens' organization of one million lay and professional members whose primary purpose is to encourage efforts to provide better services for the mentally disabled;

(4) The Association for Retarded Citizens—California, a voluntary organization of 24,000 members devoted to promoting the welfare of mentally retarded children and adults;

(5) The American Civil Liberties Union, an organization of 200,000 members engaged in defense of the principles in the Bill of Rights;

(6) The Mental Health Law Project, a nonprofit public-interest organization established in 1972 to protect the legal rights of mentally handicapped persons. MHLP has represented thousands of mentally disabled persons in individual cases and class action lawsuits establishing fundamental rights and has assisted other attorneys throughout the country in upholding the rights of their mentally handicapped clients.

retarded persons in settings which are as normal and conducive to the exercise of personal freedom as possible. While the nature of such settings will vary according to individual educational and therapeutic needs, *amici* believe that mentally retarded citizens need—and Congress intended them to have—a maximum opportunity to develop their potential for intellectual and personal growth and for the exercise of constitutionally protected liberties.

As organizations composed of thousands of professional members, *amici* draw on the extensive experience of practitioners who daily strive to provide mentally retarded and other developmentally disabled people with effective programs and services. *Amici* organizations also include mentally retarded consumers, their parents and lawyers, who are continually engaged in efforts to secure those services. *Amici* believe that developmentally disabled children and adults gain intellectual, social and physical skills more readily in small, homelike settings integrated into ordinary community life around them than they do in large, impersonal institutional settings. In fact, *amici* believe, for vast majority mentally retarded people institutional life is affirmatively harmful. In an institution, the regimented routine, the anonymity born of being one of hundreds, the isolation from family, friends and normal role models and the lack of opportunity to participate in common neighborhood affairs further retard the residents' already impaired ability to learn daily living skills, to develop meaningful personal relationships and to live self-sustained lives. Therefore, *amici* support the goal of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000 *et seq.* (hereinafter the "DD Act") to expand needed community alternatives to institutional care.

Amici do not categorically oppose the use of institutions for certain mentally retarded persons, provided the state can demonstrate that their physical and mental condition is so impaired that they could not exercise their civil liberties if placed in a less restrictive setting and

could not profit intellectually or emotionally from a more normal environment. In this case, until individual evaluations of all Pennhurst residents have been completed (as ordered by the Third Circuit Court of Appeals), the number of residents, if any, who could remain at Pennhurst is unknown. Therefore, the character of Pennhurst's residents, the way the institution would serve its reduced population and the nature of its programs are all undetermined. This Court need not decide at present whether such an undefined Pennhurst must be closed.

Consents from both petitioners and respondents to the filing of this brief have been filed in this Court.

SUMMARY OF THE ARGUMENT

The question in this case is whether residents of Pennhurst State Hospital, mentally retarded persons receiving services through a program assisted under the DD Act, have a right under that Act to receive appropriate habilitation in the least restrictive setting.[2] *Amici* maintain that the Pennhurst residents do have such a right and that both the DD Act and 42 U.S.C. § 1983 provide them a remedy for its enforcement. Therefore, *amici* urge the Court to affirm the Third Circuit's ruling requiring the petitioners to provide each respondent with a competent professional assessment of his or her habilitation needs. This Court should also affirm the Third Circuit's ruling requiring petitioners to provide each respondent with suitable community living arrangements and with other appropriate habilitation services outside Pennhurst except where petitioners can demonstrate that certain residents can receive better services at Pennhurst.

1. The plain language of the DD Act, its overall scheme and its legislative history demonstrate a strong

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[2] The term habilitation is used herein to refer to the education, training and care required by mentally retarded individuals to reach their maximum development. *Halderman* v. *Pennhurst State Hospital*, 446 F. Supp. 1295, 1298 (E.D. Pa. 1978), *aff'd*, 612 F.2d 84, 95 (3d Cir. 1979).

congressional intent to require states receiving federal funds under the Act to conform existing public programs for mentally retarded people to meet their needs both for appropriate services and for maximum liberty and autonomy. When it enacted the DD Act in 1975 Congress understood the harms mentally retarded people suffer from unnecessary confinement in large public institutions. Knowing that the vast majority of mentally retarded people have potential for intellectual and social growth and that such potential can best be developed in community settings, Congress passed a law to promote the use of community alternatives to institutionalization. To attain this goal, Congress exercised its constitutional spending authority to create a state grant-in-aid program which (1) provides funds to the states to coordinate their existing federally assisted and other programs to better serve mentally retarded persons; (2) recognizes the right of developmentally disabled persons to receive appropriate habilitation in the least restrictive setting; and (3) creates an obligation on the part of states accepting funds under the Act to protect this newly recognized right.

2. Pennsylvania applied for and received funds under the DD Act. As a condition to receiving those funds from the federal government, the Commonwealth agreed to protect the right to habilitation of developmentally disabled persons receiving services in programs assisted under the Act. Pennhurst residents are such persons. The Commonwealth operates a statewide comprehensive mental retardation program, established pursuant to Pennsylvania's Mental Health and Mental Retardation Act of 1966, which is assisted under the DD Act. The program has annually received funds under the DD Act to defray the cost of planning, securing and evaluating mental retardation services, including those provided by the state's mental retardation program. The state acknowledges that Pennhurst is an integral part of that program. As persons served in a component of the state's

program thus assisted, residents of Pennhurst have a right to appropriate habilitation enforceable against the state.

3. The record in the case leaves no doubt that the Commonwealth and its counties failed to provide appropriate habilitation to residents of Pennhurst. It is essentially unchallenged on appeal, that conditions at Pennhurst were "abominable" and "deplorable" and that they precluded any effective programming or services to improve the plight of the residents.

4. Because residents of Pennhurst have a right under the DD Act to receive appropriate habilitation from the Commonwealth and because Pennsylvania failed to provide it, those residents have a cause of action both under the DD Act itself and under 42 U.S.C. § 1983 for its enforcement. Each of the criteria for implying a private cause of action is met with respect to the DD Act. Moreover, like the plaintiffs in *Maine* v. *Thiboutot*, —— U.S. ——, 100 S. Ct. 2502 (1980), respondents in this case are beneficiaries of a federal-state grant-in-aid program seeking to enforce federally required state plan provisions against the state. This Court held in *Thiboutot* that federal enforcement provisions in the Social Security Act were not exclusive and that Section 1983 provides a remedy for the private enforcement of such rights. The same should be true in this case, especially in light of Congress' express recognition of respondents' right under the DD Act.

The Court should affirm the order of the Third Circuit Court of Appeals.

ARGUMENT

Introduction

Amici herein recognize that the scope and nature of the Court's decision in this case will have a profound effect upon mental disability law and upon the lives of hundreds of thousands of mentally disabled persons in our

country. *Amici* have joined together out of a common interest in the promotion of community-based services for mentally retarded children and adults and a concern that the Court's decision in this case speak directly and positively to the limited issues presented.

In this case, it is indisputable that the Commonwealth of Pennsylvania has received federal funds under the DD Act; that Pennsylvania operates a statewide mental retardation program; that Pennhurst State Hospital is an integral part of that program; that respondents are residents of Pennhurst; and that at the time of trial Pennhurst did not provide appropriate habilitation to its residents. The limited question presented is whether residents of Pennhurst have a right under the DD Act to receive appropriate habilitation outside of Pennhurst from the Commonwealth of Pennsylvania.

Accordingly, in order to rule on the holding of the court of appeals below, this Court need *not* decide:

1. Whether developmentally disabled persons who are not served by a state receiving funds under the DD Act have a right to habilitation under the Act;

2. Whether developmentally disabled persons who are not served by a program assisted under the DD Act have a right to habilitation under the Act;

3. Whether the DD Act requires the closure of Pennhurst as it may exist in the future. (The record does not now indicate the number of residents, if any, who will be found to need placement in Pennhurst, the kind of programs to be provided them or the future condition of the physical environment.)

4. Whether residents of Pennhurst have rights under other laws or the Constitution of the United States which support the relief ordered by the court of appeals.

Amici believe that other issues discussed in the court of appeals' dissent, but which need not be decided in order to resolve the instant case, should not be addressed

by the Court. If the Court were to find that respondents do not have a right to habilitation in the least restrictive alternative under the DD Act or Pennsylvania law, this case should be remanded to the court of appeals for its consideration of alternative grounds supporting the district court's orders. Because those alternative grounds have not been raised or briefed by the parties in this Court or ruled on by the court of appeals, they should not be decided by this Court at this time. Rather these issues should await decision in future cases, when they must be decided in order to render a holding on the merits.

I. IN AN EXERCISE OF ITS SPENDING AUTHORITY, CONGRESS CONDITIONED THE RECEIPT OF DD FUNDS UPON EACH STATE'S AGREEMENT TO PROTECT THE RIGHT TO APPROPRIATE HABILITATION OF PERSONS RECEIVING SERVICES UNDER ASSISTED PROGRAMS.

A. In Enacting the DD Act, Congress Intended to Promote Community Alternatives to Institutional Care.

When it enacted the DD Act, Congress was aware of the harms of institutionalization and intended to promote the use of less restrictive alternative habilitation services. Congress had become increasingly concerned about the large numbers of mentally retarded persons being confined in public institutions where they were subjected to inhumane conditions[3] and inappropriate treatment,

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[3] . . . Over the last two years the Committee on Labor and Public Welfare has taken testimony or received reports of: inappropriate admissions because of lack of community services, inappropriate and inhuman experimentation with residents, sterilizations and other operations performed for convenience of treatment, starvation and malnutrition, abuse and physical punishment and inadequate food and living conditions, and death.

121 Cong. Rec. 16,516-17 (June 2, 1975) (remarks of Senator Williams).

Similar findings regarding inhuman conditions in the nation's large retardation institutions were made by several federal courts

where their liberty was unnecessarily restricted[4] and where their disabilities were aggravated.[5] President Kennedy had implored the nation that "we must move from the outmoded use of distant custodial institutions to the concept of community-centered agencies." 1963 Public Papers of the President 126, 134; 109 Cong. Rec. 1832, 1841 (1963).

While the overwhelming weight of professional opinion expressed to Congress supported the provision of community residential care and services to persons inappropriately placed in institutions, there was an acknowledged lack of community facilities available in which to place them.[6] To remedy this situation, in 1975 Con-

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and specifically regarded by Congress as the wrongs to be righted by the new Act. *Wyatt* v. *Stickney*, 344 F. Supp. 387, 391 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *New York State Association for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752, 756 (E.D. N.Y. 1973). *See* 121 Cong. Rec. 16,516-17 (April 10, 1975); 124 Cong. Rec. S 15,663 (*daily ed.*, Sept. 21, 1978).

[4] The prevailing professional opinion expressed to the Congress during its hearings on the DD Act was to the effect that mental retardation is not a deviance or a disease, but an impairment in learning capacity and adaptive behavior which can be improved through education and training. *Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973:* Hearings on S. 427 and S. 458 Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare, 93rd Cong., 1st Sess. 1973. This concept, known as the developmental model, was adopted by Congress as one of the principles underlying the 1975 Bill of Rights provisions in the Act. S. Rep. No. 160, 94th Cong., 1st Sess. 28 (1975) (hereinafter "S. Rep. No. 94-160").

[5] Stimpson, *et al., Effects of Early Institutionalization on Growth and Development of Young Children with Down's Syndrome*, 67 Mich. Med. 1213 (1968); Kaufman, *The Formation of a Learning Set in Institutionalized and Non-Institutionalized Mental Defectives*, 67 Am. J. Men. Def. 601, 604 (1963); Sternlight & Siegel, *Institutional Residence and Intellectual Functioning*, 12 J. Men. Def. Res. 119, 123 (1968).

[6] *See generally Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973:* Hearings on S. 427 and S. 458

gress enacted the DD Act to provide states with funds to plan, coordinate and evaluate the development of community-based services as alternatives to institutionalization.[7] Congress also adopted a bill of rights provision expressly granting developmentally disabled people a right to receive appropriate habilitation in the least restrictive setting. Finally, as a condition to receiving DD funds, Congress required that each participating state protect that expressly provided right in all programs assisted under the Act.

Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare, 93rd Cong., 1st Sess. (1973).

[7] The Senate Committee, reporting on the 1975 Act placed "high priority" on "utilization of community resources and alternatives to institutionalization." S. Rep. No. 94-160 at 16. Although the Act provides standards for residential programs, Section 6010(3) and (4)(A) and (B), they should not be construed as implying congressional approval of traditional large public institutions. S. Rep. No. 94-160 at 32-33 (1975). On the contrary, they represent an effort to require that residential programs be appropriate to the needs of their residents—something Congress believed large institutions like Pennhurst were not. Thus the Act proclaims: "It is in the national interest to strengthen specific programs [for developmentally disabled people] especially programs that reduce or eliminate the need for institutional care." 42 U.S.C. § 6000(a)(5).

A policy favoring deinstitutionalization has also been embodied in other major legislation, including amendments to the Vocational Rehabilitation Act in 1964 and 1968, 29 U.S.C. §§ 31 to 35, 37, 38, 41 to 41c, 42-1 to 42b (1976) (providing group residences and services for retarded persons); Rehabilitation Act of 1973, 29 U.S.C. §§ 701-794 (1976) (requiring rehabilitation services for more severely disabled persons); Social Services Amendments of 1974, 42 U.S.C. §§ 1397-1397f (1976) (setting deinstitutionalization as a goal); Education for All Handicapped Children Act of 1975, 20 U.S.C. §§ 1232, 1401, 1405, 1406, 1411-1420, 1453 (1976) (assuring public education for children with special needs); National Health Planning and Resource Development Act of 1975, 42 U.S.C. 300l, 300k-2 (1976) (setting deinstitutionalization as a national health priority).

B. The DD Act Provides Funds to States for the Coordination of Federally Assisted Programs to Provide Community Alternatives.

It is clear from the terms of the Act and its legislative history, that Congress intended that federal funds for services to mentally retarded people—more than 3.5 billion dollars in 1981 and commensurate amounts in previous years [3]—be used to provide appropriate habilitation to the mentally retarded population in noninstitutional settings. The Act was not intended to provide a new funding source for the operation of needed services for mentally retarded persons. Rather, it was a source of funds for the planning, coordination and marshaling of existing public programs and funding sources to provide appropriate services.

By 1975, Congress had already enacted a number of social welfare and benefit programs which, properly utilized, provided large sums of money to finance the cost of community services to mentally disabled people. These programs included Supplemental Security Income, Vocational Rehabilitation, Education for All Handicapped Children, the social services program of Title XX of the Social Security Act, Medicaid and others. They provide federal funds for the operation of a wide variety of residential, educational, medical and social services utilized by developmentally disabled people outside of institutions.[9] In 1979, HEW spent almost $2.8

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[8] *Testimony of the Secretary of Health and Human Services: Special Reports, Departments of Labor, Health, Education, and Welfare, and Related Agencies Appropriations for 1981:* Hearings Before a Subcomm. on Appropriations, 96th Cong., 2d Sess. 641-674 (1980) (hereinafter "HHS Special Report").

[9] The major federal programs currently providing significant noninstitutional services to mentally retarded people include the Supplemental Security Income program under the Social Security Act, providing maintenance income to mentally disabled people, 42 U.S.C. §§ 1381 *et seq.*; the Title XX social services program providing funds for foster care, day activities programs, social work counseling and referral services, as well as grants for the establish-

billion to serve mentally retarded people alone through such programs.[10] The states spend billions more.

Congress saw no need to spend more money for direct services. It desired, instead, to see that funds already available were properly used to provide appropriate services. Congress clearly indicated that it intended to use the leverage of additional federal funds provided by the DD Act to influence a broad range of service programs. In its 1975 report, the Committee on Interstate & Foreign Commerce stated its intention to reach the entire spectrum of programs:

> The developmental disabilities program itself provides only approximately one percent of all the funds available from Federal, State and local sources for services of various kinds to the developmentally disabled. *The intent of the State formula grant provisions of the 1970 Act was to provide for more effective planning* by the States of their programs. . . . A program which provides only one percent of available funds must have its impact through *improving the effectiveness and efficiency of the use of the rest of available funds.*

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ment of small facilities, 42 U.S.C. §§ 1397 *et seq.*; the Medical Assistance program under Title XIX of the Social Security Act, providing funding for residential facilities for as few as four persons to provide intermediate care for mentally retarded people, as well as funds for habilitation services such as physical therapy, psychiatric counseling and physicians' services, 42 U.S.C. §§ 1396 *et seq.*; the Vocational Rehabilitation program, providing evaluations of employment potential, prevocational and vocational training and sheltered employment placement, 29 U.S.C. §§ 701 *et seq.*; the Education for All Handicapped Children Act, providing funds to public school systems for special education programs to meet the needs of mentally as well as physically handicapped children, 20 U.S.C. §§ 1401 *et seq.* (1975); and housing programs providing federal subsidies to support the development of special sheltered congregate-living arrangements for the mentally handicapped, 42 U.S.C. § 1437(f), 12 U.S.C. § 1701(1).

[10] HHS Special Report, *supra.*

H.R. Rep. No. 94-58, 94th Cong., 1st Sess. 10 (1975), *reprinted in* [1975] U.S. Code Cong. & Ad. News 924 (emphasis added).[11]

Again in 1978, Congress re-emphasized this leveraging principle underlying the legislation:

> When Congress originally passed the Developmental Disabilities Act in 1970, the legislation was seen as a planning, coordinating and gap-filling mechanism which would assist consumer representatives, service providers, and responsible state officials to make rational sense of the growing array of Federal and State programs to finance and deliver services to a target population of some of the most severely handicapped persons in our society. In essence, the program was intended to be *a catalyst—to weld into a cohesive, client centered thrust the expanding number and types of specialized and generic programs with responsibility for assisting developmentally disabled individuals.* The program was to serve as the *glue* to hold together all the major structural components of a comprehensive, lifelong program for developmentally disabled persons.

H.R. Rep. No. 95-1188, 95th Cong., 2d Sess. 9-10, *reprinted in* [1978] U.S. Code Cong. & Ad. News 7364 (emphasis added).

Congress' intention to establish in the DD Act requirements to be enforced in other federally assisted programs is made clear by Section 6010(3) of the Act. It provides:

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[11] Indeed, the coordination of federal, state and local programs was seen as an essential task of the state planning councils created by the Act. 42 U.S.C. § 6067; 45 CFR § 1386.61 (1978).

The Planning Council, through its activities under the DD Act, can avoid duplicating services, financing inappropriate services and failing to provide essential services for the developmentally disabled population. It is inevitable that the programs represented on Pennsylvania's Planning Council (among them the state's mental retardation, medical assistance, vocational rehabilitation and special education programs) benefit from and are assisted by the DD Act's planning mandate.

> The Federal Government and the States both have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that (A) does not provide treatment, services, and habilitation which are appropriate to the needs of such persons; or (B) does not meet the following minimum standards: . . .

42 U.S.C. § 6010(3). This prohibition applies to the expenditure of all state and federal funds, not just those provided by the DD Act. This section is evidence of Congress' intention to use the DD Act to affect the states' use of other federal funds, such as those provided for special education, vocational rehabilitation and Medicaid —all of which provide some funds for residential services. This same purpose is evident in the state plan requirements which impose upon participating states an obligation to protect the right to appropriate habilitation in such programs when those programs are assisted under the DD Act.

Contrary to petitioners' contention, the federal government is a true financial partner with the states in the provision of services to mentally retarded people. It contributes billions of dollars annually to the states, including Pennsylvania, to provide such services.[12] Rather than placing a "massive burden" upon the states and providing no funds to meet it, the DD Act requires those states which accept DD funds for the coordination of existing federally funded programs to take action in accordance with the plans the Act pays to develop. Congress was not interested in paper exercises. It wanted and demanded assurances from participating states that they would conform federally assisted services to congressional objectives. Furthermore, the court of appeals noted that the development of suitable community living arrangements in Pennsylvania will impose little, if any, financial burden on the state and counties. The district

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[12] HHS Special Reports, *supra*, at 643.

court found that the per-patient cost in a community living arrangement is less than at Pennhurst, and this finding was not challenged on appeal. 612 F.2d 116 n.39.[13]

C. To Ensure the Use of Community Alternatives, Congress Expressly Recognized in Section 6010 of the DD Act a Right of Developmentally Disabled People to Receive Appropriate Least Restrictive Habilitation.

Deploring the wasted human potential and the unjustified denial of freedoms caused by unnecessary institutional confinement, and intent upon promoting the use of alternatives, Congress added the Bill of Rights to the DD Act in 1975. 42 U.S.C. § 6010. These provisions state

> Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation for such disabilities. 42 U.S.C. § 6010(1).

The "appropriate habilitation" to which the Act establishes a right is not an absolute concept, but one which takes into account two important personal interests—the therapeutic and the civil libertarian. The Act thus defines habilitation as those services which are both "designed to maximize the developmental potential for the person" and which are "provided in the setting least restrictive of the person's personal liberty." 42 U.S.C. § 6010(2).

The concept of appropriate habilitation is one of a spectrum or continuum of services, each suited to dif-

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[13] Studies indicate that community care systems not only benefit retarded people more, both intellectually and socially, but are also less costly, or at least no more expensive, than institutional care. *See, e.g.*, Intagliata, *Cost Comparison of Institutional and Community Based Alternatives for Mentally Retarded Persons*, 17 Mental Retardation 154 (1979); GENERAL ACCOUNTING OFFICE, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY 5-6 (1977); Rubin, *An Economic Analysis of Litigation and Legislation for the Handicapped, in* BUREAU OF ECONOMIC RESEARCH, DISABILITY AND HEALTH ECONOMICS RESEARCH 102 (1976).

ferent degrees of disability and different sets of needs. At one end of the spectrum are large institutions; at the other end are small group homes or supervised independent apartment programs and an array of nonresidential community support services. Congress meant to entitle all developmentally disabled people, not to a particular place in the spectrum, but to those services which would best meet each individual's developmental needs.[14]

Apart from the enforceability of the rights recognized in Section 6010 standing alone, those rights are clearly made enforceable by the Act's Section 6063 state plan requirements. These requirements obligate the states to protect those rights.

D. The DD Act's State Plan Requirements in Section 6063 Obligate Each Participating State to Provide Appropriate Habilitation in Its Assisted Programs.

The mechanism Congress selected to effectuate the right to appropriate habilitation was the familiar state grant-in-aid program. Exercising its spending authority to provide for the general welfare under Article I, Section 8 of the Constitution, Congress offered the states planning funds in exchange for a commitment to carry out congressionally declared objectives—*i.e.*, the state's commitment to coordinate and utilize its assisted programs to provide appropriate habilitation in the least restrictive setting.[15] This Court has made it clear that "[t]here is, of course, no question that the Federal Government, unless barred by some controlling constitutional prohibition, may impose terms and conditions upon which

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[14] 42 U.S.C. § 6011.

[15] As the Third Circuit noted, recognition of the DD Act as an exercise of spending authority is in no way inconsistent with the bill of rights provisions' also being an exercise of Congress' authority under Clause 5 of the Fourteenth Amendment. 612 F.2d at 99.

its money allotments to the states shall be disbursed." *King* v. *Smith*, 392 U.S. 309, 333 n.34 (1968).[16]

The terms and conditions imposed upon states accepting federal funds under the DD Act are contained in the state plan requirements in Section 6063 of the Act. Section 6063 of the Act requires each recipient state to obligate itself in its state plan to, among other things, (1) determine the services needed by persons with developmental disabilities which are provided or will be provided by federal-state programs, (2) provide that services are delivered in an individualized manner consistent with the Act's requirements for individualized habilitation plans in Section 6011 and (3) assure that the rights of developmentally disabled people to appropriate habilitation secured by the Act's bill of rights provision (in Section 6010) will be protected.[17] Taken together, these state plan requirements create obligations on the part of the states corresponding to the rights granted by Sections 6010 and 6011 of the Act to developmentally disabled people served in state-assisted programs.

Subsection 6063(b)(5)(C) of the Act mandates that the state's plan provide for the protection of the right to appropriate habilitation in the least restrictive setting:

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[16] *See, e.g., Lau* v. *Nichols*, 414 U.S. 563, 569 (1974); *Rosado* v. *Wyman*, 397 U.S. 397, 408 (1970); *Oklahoma* v. *Civil Service Comm.*, 330 U.S. 127, 142-43 (1947). In *Lau*, this Court again confirmed that "the Federal Government has power to fix the terms on which its money allotments to the States shall be disbursed." *See also Conn. State Dep't. of Public Welfare* v. *HEW*, 448 F.2d 209, 215 (2d Cir. 1971) (Social Security Act grant-in-aid programs, 42 U.S.C. §§ 600 *et seq.*); *North Carolina ex rel. Morrow* v. *Califano*, 445 F. Supp. 532 (E.D.N.C. 1977), *aff'd mem.*, 435 U.S. 962 (1978) (National Health Planning and Resources Development Act (1978) (National Health Planning and Resources Development Act, 42 U.S.C. §§ 300k *et seq.*). *See generall*, R. CAPPALLI, RIGHTS AND REMEDIES UNDER FEDERAL GRANTS 28-34 (1979); Wallick & Montalto, *Symbiosis or Domination: Rights and Remedies Under Grant Type Assistance Programs*, 46 Geo. W.L. Rev. 159 (1978).

[17] Subsections 6063(b)(2)(A) and (B) and (b)(5)(B) and (C).

> The plan must contain or be supported by assurances satisfactory to the Secretary that the human rights of all persons with developmental disabilities (especially those persons without familial protection) who are receiving treatment, services, or habilitation under the *programs assisted under this chapter* will be protected consistent with section 6010 of this title (relating to rights of developmentally disabled) (emphasis added).

The obligations created by subsection 6063(b)(5)(C) thereby accrue to persons who receive services "under the 'programs assisted' under [the Act]."

II. IN ORDER TO OBTAIN FUNDS UNDER THE DD ACT, PENNSYLVANIA AGREED THAT IT WOULD PROTECT THE RIGHT TO APPROPRIATE HABILITATION OF PERSONS RECEIVING SERVICES IN ASSISTED PROGRAMS.

Petitioners, the Commonwealth of Pennsylvania, applied for and received funds from the federal government under the Developmental Disabilities Act in 1977, 1978, 1979 and 1980. As discussed above, in order to obtain those funds, the Act required Pennsylvania to assure the Secretary of Health and Human Services that it would protect the rights of "all persons with developmental disabilities . . . who are receiving treatment, services or habilitation under programs assisted under the Act consistent with Section 6010 (the bill-of-rights provisions)." Subsection 6063(b)(5)(C).[18] The respondents are such persons. They currently receive at least some, albeit inadequate, services at Pennhurst, which is part of

[18] Under the terms of Subsection 6063(b)(5)(C), states assure that the rights of certain persons will be protected. Where the Commonwealth provides services through contractual and other arrangements with its counties, it must require the counties to abide by the conditions which bind the state. Consequently, in this case, the obligations incumbent upon the Commonwealth by virtue of its state plan assurances are also incumbent upon the counties which participate in the state's mental retardation program.

the state's mental retardation program assisted under the Act.

A. Pennhurst Is Part of Pennsylvania's Mental Retardation Program, Which Is a "Program" Within the Meaning of Subsection 6063(b)(5)(C).

Petitioners contend that assisted programs are only those facilities that directly receive funds under the Act. Pet. Brief, at 16. However, the "programs assisted" under the Act must refer to broad statewide service programs rather than narrow, individual operating facilities. These state plan requirements would be rendered meaningless if "programs" mentioned in Section 6063(b)(5)(C) did not signify statewide service programs. The term is used in its broad sense, to include statewide programs, in the preceding provisions of the same section, where Subsection 6063(b)(2)(A) requires the state to list the programs it will use to meet its designated objectives, and Subsection 6063(b)(2)(B) requires the state to describe such "Federally assisted State programs as the State conducts relating to education for the handicapped, vocational rehabilitation, public assistance, medical assistance, social services, maternal and child health, crippled children's services and comprehensive health and mental health," which will be used to provide services to developmentally disabled people in the state. It is reasonable to assume, then, that the term "program" as used in Subsection 6063(b)(5)(C) again means statewide service programs.

Moreover, a more restricted reading of the term "assisted program" to mean only those programs directly receiving funds appropriated under the DD Act is contrary to the expressed intent to condition DD funding upon the states' willingness to provide individualized habilitation plans and appropriate habilitation in state-operated programs. Indeed, if the state's obligations to provide services meeting federal standards, to provide individualized services and to protect the rights of developmentally disabled people are construed to run only with

direct DD funding, the Act is made a mockery. It would obligate the states to respect the rights of only those very few developmentally disabled people who are served by university-affiliated programs or by model demonstration programs.[19] Surely Congress did not labor so hard to bring forth such a mouse.

Congress, *amici* believe, had larger objectives in mind when it established these state plan requirements. It meant to require states which accept federal planning money to respect the rights of developmentally disabled people in all of the state's programs assisted through the planning, evaluation and coordination efforts funded by the Act. Whatever the reaches of such assistance might be in other cases, in this case the Commonwealth's own mental retardation program was clearly such an assisted program.

By its own acknowledgment, respondent Commonwealth of Pennsylvania maintains a single statewide mental retardation program intended to provide a wide variety of services to developmentally disabled persons. As set forth in its 1980 Developmental Disabilities Plan:

> The legal base for [Pennsylvania's] mental retardation program is the Mental Health and Mental

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[19] Under such a narrow interpretation of Section 6063, if a state desired to completely defeat the individual rights granted in § 6010, it could allot all of its DD Act funds to nonservice activities, such as those which promote public awareness projects and personnel training. Even when DD Act funds in any given year *are* designated to a program that provides treatment, habilitation or service, because of the nature of the Act there is no assurance that the funding will attach to the program in subsequent years. If direct DD funding were the key to § 6063's required assurances, a resident in a community living arrangement facility which might directly receive DD Act funds in 1979 would lose his right to receive appropriate treatment in the least restrictive environment if the DD monies were directed elsewhere in 1980. Under this reading, the rights established by Congress would attach and pass away on a mere change of bookkeeping entries. The Congress could not have meant these rights to be so transient or so easily evaded by recipient states.

> Retardation Act of 1966, which charges the Department of Public Welfare with the duty to assure within the state the availability and equitable provision of adequate mental health and mental retardation services for all persons who need them regardless of religion, race, color, national origin, settlement, residence or economic or social status.

Pennsylvania Developmental Disabilities Plan, 1980 at 191. Under the Mental Health and Mental Retardation Act of 1966, the counties and the state share administrative and financial responsibility for providing comprehensive services to all mentally retarded people in the state.[20]

The legislative history of the 1966 Act indicates that the Pennsylvania legislature believed that it was creating "the framework of a program which will provide a continuum of services" to the state's mentally handicapped. Remarks of Senator Pechan, 1966 Pa. Legis. J. 3d Spec. Sess., No. 33, 76 (Sept. 27, 1966). The Commonwealth's share of the cost of operating Pennsylvania's mental retardation program comes through a single appropriation to the program as a whole. Pennsylvania's Governor's Executive Budget, 1979-1980 at 47.

The Pennsylvania courts have also recognized that the 1966 Act mandated the creation of a single statewide program:

> The manifest object of the General Assembly in enacting the Mental Health and Mental Retardation

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[20] Pa. Stat. Ann. tit. 50, §§ 4101-4704 (Purdon 1969). When an individual resides in a state institution, the Commonwealth pays 100% of the costs; however, if the individual resides in the community, the counties must provide 10% of the funds necessary to provide some of the services. 446 F. Supp. 1312. In 1970, Act 256 became law, appropriating $21 million for the purposes of planning, designing and constructing community facilities which would enable 900 Pennhurst residents to be transfered to the community. Eighteen million dollars of this fund remains unspent. As of April 1977, only 37 Pennhurst residents had directly benefited from Act 256. *Id.*

> Act of 1966 was to create a cooperative State-county (or multi-county) program across the Commonwealth for those who suffer mental health or mental retardation afflictions.

Hoolick v. *Retreat State Hospital*, 24 Pa. Commonw. Ct. 218, 224; 354 A.2d 609, 612 (1976), *aff'd*, 476 Pa. 317, 382 A.2d 739 (1978).

The program has three major subsystems, represented in its state plan as:

> . . . interrelated but not yet fully integrated. These subsystems include: (1) the State Center system; (2) the County MH/MR system; (3) private services for the mentally retarded.

Pennsylvania Developmental Disabilities Plan, 1980 at 191. *See also* Pennsylvania Developmental Disabilities Plan 1979, at 107-109. Pennhurst, a State center is unquestionably an important component of the mental retardation program, as admitted by the petitioners in their brief to this Court: "Institutional care remains an integral part of Pennsylvania's diversified program for the mentally retarded." Pet. Brief, n.2.

B. Pennsylvania's Mental Retardation Program Is "Assisted" Under the DD Act Within the Meaning of Subsection 6063(b)(5)(C).

Having established that the Commonwealth's mental retardation program is a program within the meaning of Subsection 6063(b)(5)(C) and that Pennhurst State Hospital is an integral part of that program, the question becomes whether the program is "assisted" by funds provided under the DD Act.

Examination of the purposes for which federal DD funds were sought by Pennsylvania and provided by the federal government leave no doubt that the Commonwealth's mental retardation program is a program "assisted" under the DD Act. The state's mental retardation program is administered by the state's Office of Mental Retardation, which receives the largest share of the

state's allotment of federal funds each year. These funds are used to defray the administrative costs of designing, securing and assessing services, including those provided through the state's mental retardation program (see Pennsylvania Developmental Disabilities Plan 1979 at 376 and Pennsylvania Developmental Disabilities Plan 1980 at 14). Not only did the federal DD funds augment state appropriations for the mental retardation program, the state's program was in fact benefited by the planning and evaluation efforts for which the federal funds were used.

As developmentally disabled individuals receiving services from a participating state through a program assisted under the Act, residents of Pennhurst are undeniably among the citizens whose rights the state obligated itself to protect. Those rights included the right to individualized habiliation plans and appropriate treatment in the least restrictive setting.

III. PENNSYLVANIA AND THE COUNTIES VIOLATED THEIR OBLIGATION TO PROVIDE RESPONDENTS WITH APPROPRIATE HABILITATION WHEN THEY CONFINED THEM IN PENNHURST STATE HOSPITAL.

As part of their obligation to provide appropriate habilitation, petitioners were required to provide competent assessment of respondents' potential for learning and development. Yet the district court found that respondents' needs were never properly assessed.[21]

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[21] None of Pennhurst's residents had received a complete, individualized assessment as of January 1977; the evaluations that were performed were found to fall below minimum professional standards. 446 F. Supp. 1295, 1305. Although required by both federal and state law to assess the needs of mentally retarded applicants for service, counties also frequently failed to perform competent evaluations. 446 F. Supp. 1295, 1313. They failed to investigate alternatives less restrictive than Pennhurst and routinely placed retarded individuals there. *Id.* Often placement at Pennhurst was the only possibility presented to the judge at court commitment proceedings. *Id.*

In addition, petitioners violated their obligations under Subsections 6063(b)(5)(C) and 6010(1) to actually provide the appropriate habilitation services that respondents were known to need. They provided only Pennhurst. Yet neither the Commonwealth nor the counties took issue with the findings, affirmed by the court of appeals, that Pennhurst was both physically and psychologically dangerous. 446 F. Supp. at 1308; 612 F.2d at 93. The record compiled in the district court vividly documents the deterioration and abuse which Pennhurst residents suffer. The court also specifically found that the programming at Pennhurst fell far below minimum professional standards. 446 F. Supp. at 1308-10. The circuit court found that Pennhurst was unsanitary, stinking, conducive to infectious diseases and excessively noisy. Residents there were subject to staff abuse, self-abuse, drug-abuse and unnecessary isolation as punishment. 612 F.2d at 93. The majority of the Third Circuit found the conditions at Pennhurst "abominable"—the dissent, "deplorable." By no stretch of the imagination could Pennhurst be considered appropriate habilitation. As the court of appeals declared, Pennhurst's operation at the time of the lawsuit was a flagrant violation of its residents' right to appropriate habilitation. 612 F.2d at 108.

IV. RESPONDENTS HAVE A PRIVATE CAUSE OF ACTION TO ENFORCE STATE PLAN REQUIREMENTS BOTH UNDER THE DD ACT AND UNDER 42 U.S.C. § 1983, AS CONSTRUED IN *MAINE* v. *THIBOUTOT*.

A. Respondents Have an Implied Cause of Action Under the DD Act in Accordance With the Criteria Established in *Cort* v. *Ash*.

Using the criteria of *Cort* v. *Ash*, 422 U.S. 66 (1975), established by this Court for the implication of a private cause of action, the DD Act itself can be construed to provide residents of Pennhurst a cause of action to enforce their rights against the state and its counties.

The court of appeals chose not to address the question whether an exercise of spending authority can support a private cause of action. 612 F.2d at 99.[22] Nevertheless, federal courts have recognized for some time the implied right of beneficiaries of federal grant-in-aid programs established pursuant to Congress' spending powers to enforce relevant state plan requirements.[23] Under the four standards of *Cort* v. *Ash*, residents of Pennhurst have an implied cause of action under the DD Act for the enforcement of the rights explicitly granted them by the bill-of-rights section and made enforceable against the states by the Act's state plan requirements.[24]

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[22] The court of appeals found an implied cause of action under the *Cort* v. *Ash* criteria regarding the bill-of-rights provisions of the DD Act as exercises of Congress' authority under Clause 5 of the Fourteenth Amendment. For the reasons stated herein a private cause of action can also be found regarding the Act as an exercise of spending authority.

[23] *See, e.g., Gomez* v. *Florida State Employment Service*, 417 F.2d 569 (5th Cir. 1969); *Euresti* v. *Stenner*, 458 F.2d 1115 (10th Cir. 1972); *Saine* v. *Hospital Authority of Hall County*, 502 F.2d 1033 (5th Cir. 1974); *NYC Coalition for Community Health* v. *Lindsay*, 362 F. Supp. 434 (S.D.N.Y. 1973). *See also Lloyd* v. *Regional Transp. Auth.*, 548 F.2d 1277 (7th Cir. 1977); *Bossier Parish School Bd.* v. *Lemon*, 370 F.2d 847 (5th Cir.), *cert. denied*, 388 U.S. 911 (1967); *Corum* v. *Beth Israel Medical Center*, 359 F. Supp. 909 (S.D.N.Y. 1973); *Cook* v. *Ochsner Foundation Hosp.*, 319 F. Supp. 603 (E.D. La. 1970).

[24] First, as discussed in section I. above, residents of state-run institutions can legitimately claim that Congress intended to benefit them specifically by requiring states receiving DD funds to protect the rights expressly granted such residents by the bill of rights.

Second, the legislative history of the DD Act does not indicate that Congress intended to foreclose private enforcement of the rights it created. Nor, for the reasons stated in subsection C below, does it show that Congress intended enforcement of state obligations by the Secretary of HHS to be the exclusive means of enforcing the Act.

Third, private enforcement is consistent with and furthers the purposes of the Act for the reasons set forth in Section I above.

B. 42 U.S.C. § 1983 Provides a Remedy for the Enforcement of Rights Secured by the DD Act.

Even if respondents did not have a private cause of action under the DD Act directly, they have a cause of action under 42 U.S.C. § 1983. As this Court has recently recognized, Section 1983 provides a remedy for the enforcement of rights secured by laws of the United States as well as of rights secured by the Constitution. *Maine* v. *Thiboutot*, —— U.S. ——, 100 S. Ct. 2502 (1980). The question before the Court, then, is: Are the rights created by the DD Act "rights . . . secured by laws" of the United States within the meaning of Section 1983?

While the full scope of the meaning of that phrase in Section 1983 may not be clear, it must include individual rights which are both expressly granted by Congress and which are also of the same kind as those enforced in the *Thiboutot* case. In that case, the plaintiffs were welfare recipients who were entitled to certain monetary benefits from the state under the federal Social Security Act. Like the DD Act, the Social Security Act's Aid to Families with Dependent Children program is a federal-state grant-in-aid program. Beneficiaries of the program sought to enforce the state plan requirements against the State of Maine and were held to have a cause of action to do so under Section 1983. A majority of this Court made clear in *Thiboutot* that Section 1983 was the exclusive statutory cause of action, available to the plaintiffs in that case because there is no private

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As providers and consumers of essential habilitation services, *amici* concur that the special vigilance and unique interest of the direct beneficiaries of the Act are essential to the effective implementation of a system of appropriate services.

Fourth, the right to receive appropriate habilitation in the least restrictive setting is not a right traditionally relegated to state law. Rather, it is a newly recognized right which a federal statute requires the states to protect if they are to receive certain federal funds. Accordingly, all of the criteria established by this Court for the implication of a private right of action are met with respect to the DD Act.

right of action against the state under the Social Security Act. *Maine* v. *Thiboutot*, 100 S. Ct. at 2506.

In determining what rights are secured by the laws of the United States for the purposes of Section 1983, the phrase should be interpreted to encompass those rights which, like those granted under the Social Security Act, are based on state obligations to operate federally assisted programs in a manner which directly benefits claimants of the right. As discussed above, the DD Act is such a law and the state's obligations are clearly provided in Subsection 6063(b)(5)(C) of the Act. Furthermore, any doubt that Congress intended to create enforceable private rights of beneficiaries is dispelled by the plain language in Section 6010 of the DD Act, absent in the Social Security Act, expressly recognizing such rights.[25]

C. Congress Did Not Intend Federal Fund Cut-Offs for Noncompliance With State Plan Requirements to Be the Exclusive Means of Enforcing Obligations Under the Act.

Petitioners contend that the ruling in *Maine* v. *Thiboutot* should not apply in this case because Congress intended the provisions permitting the Secretary of HHS to cut off federal funds to be the exclusive mechanism for enforcement of state obligations under the DD Act. Pet. Brief, at 28-34. But as set forth below, petitioners have misread or misstated the intent of Congress. Furthermore, in *Maine* v. *Thiboutot*, the Court did not find that similar mechanisms for enforcement by the Secretary of HHS were exclusive or precluded the recognition of a

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[25] As noted in the majority opinion in *Maine* v. *Thiboutot*, an action under section 1983 is supported by federal question jurisdiction under 28 U.S.C. § 1331. —— U.S. ——, 100 S. Ct. 2502, 2504 n.6. In this case, the jurisdictional amount of $10,000 is more than met by the fact that the cost of caring for each resident at Pennhurst is $21,000 a year (446 F. Supp. at 1312)—funds respondents claim the DD Act requires be used to provide them appropriate habilitation.

private cause of action under Section 1983 to enforce state plan requirements. This Court in *Regents of University of California* v. *Bakke*, 438 U.S. 265, 420 n.26 (1970) stated:

> The notion that a private action seeking injunctive or declaratory judgment relief is inconsistent with a federal statute that authorizes termination of funds has clearly been rejected by this Court in prior cases. *See Rosado* v. *Wyman*, 397 U.S. 397, 420.

The enforcement mechanism in the DD Act (42 U.S.C. § 6065; 45 CFR §§ 1386.80 *et seq.*) cannot have been intended as the exclusive method for the enforcement of individual rights granted to beneficiaries by the Act, for it fails to provide any remedy for the infringement of individual rights which do not constitute substantial noncompliance for the state as a whole.

As this Court observed in *Cannon* v. *University of Chicago*, 441 U.S. 677 n.42 (1979), in connection with enforcement of rights under Title IX of the Civil Rights Act, "[a]s a special matter HEW cannot hope to police all federally funded education programs, and even if administrative enforcement were always feasible, it often might not redress individual injuries." Petitioners clearly misunderstand the nature of enforcing state compliance with DD requirements; it is not simply a matter of paper submissions, but involves the difficult task of overseeing the performance of the many facilities and agencies responsible for delivering services to developmentally disabled people. Therefore, individual enforcement mechanisms are as crucial here as those found necessary to assure Title IX rights.

In fact, Congress recognized in 1975 that the rights it granted would be individually enforced. Both the Conference Report and debate on the bill-of-rights provisions indicate that the Congress expected the newly recognized rights to be enforced in the courts:

> [T]he developmentally disabled . . . have a right to receive appropriate treatment for the conditions for

> which they are institutionalized, and that this *right should be protected and assured* by the Congress *and the courts.*

H.R. Conf. Rep. No. 473, 94th Cong., 1st Sess. 42, *reprinted in* [1975] U.S. Code Cong. & Ad. News 961 (emphasis added).

Again, during debate on the 1978 amendments, members of Congress emphasized that the rights set forth in Section 6010 were enforceable:

> Everyone in here knows that the only way that change is going to be brought about [in institutions like Willowbrook and Forest Haven] is the long, difficult, persistent, and dedicated advocacy of those who are prepared to follow through administrative hearings, hearings on regulations, *through challenges in the court, for the kinds of rights which are being guaranteed in this legislation.*

124 Cong. Rec. 15,663 (September 21, 1978) (remarks of Senator Kennedy) (emphasis added). The DD Act itself creates protection and advocacy agencies in each state and charges them with the responsibility "to pursue legal remedies to insure the protection of the rights of [developmentally disabled] persons who are receiving treatment, services or habilitation within the State." Section 6012(a).

Enforcement mechanisms similar to those set forth explicitly in the DD Act, including noncompliance hearings by federal agencies and the cut-off of federal funds, have been provided in the Hill-Burton statute, 42 U.S.C. § 291g; the Wagner-Peyser National Employment System Act, 29 U.S.C. § 49h; Title IX of the Civil Rights Act, 20 U.S.C. § 1682, and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, Exec. Order No. 11914 (April 28, 1976). But the existence of those parallel enforcement mechanisms has not precluded the implication of private rights of action under those Acts. *Cook* v. *Ochsner Foundation Hosp.*, 319 F. Supp. 603 (E.D. La. 1970); *Gomez* v. *Florida State Employment*

Service, 417 F.2d 569 (5th Cir. 1969); *Cannon* v. *University of Chicago*, 441 U.S. 667 (1979); *Lloyd* v. *Regional Transp. Auth.*, 548 F.2d 1277 (7th Cir. 1977). More importantly, similar enforcement provisions in the Social Security Act, 42 U.S.C. 604, did not prevent this Court in *Thiboutot* from recognizing a private right under 42 U.S.C. § 1983 to enforce state obligations under that Act.

Not having the benefit of this Courts' opinion in *Maine* v. *Thiboutot*, the court of appeals below held that respondents have an implied cause of action under the DD Act for enforcement of the rights granted them by the bill of rights. *Amici* urge the Court to affirm that holding or hold that respondents have a cause of action under Section 1983 for the enforcement of these rights.[26]

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[26] The court of appeals made clear that it expected the Commonwealth and the counties to provide each respondent with a competent evaluation of his or her needs. 612 F.2d at 112, 115 and 116. The district court or its appointed master is to review the counties' professional determinations to find whether an improved Pennhurst is the only appropriate placement for persons designated to be placed or retained there. *Id.* at 114. In performing that review, the court is to engage a presumption in favor of placing individuals in community living arrangements. *Id.* at 115. *Amici* believe that enforcement of the petitioners' obligation to provide respondents competent professional evaluations and adequate habilitation program plans is proper.

Furthermore, because it has not yet been determined whether each respondent's right to appropriate habilitation in the least restrictive setting is being violated by petitioners, it is proper to provide for judicial review of these professional assessments in this litigation. In *Parham* v. *J.L.*, 442 U.S. 584 (1979), this Court ordered similar relief. Because, on the record of that case, this Court could not decide if every child in the class had been accorded minimal due process, including an adequate independent diagnosis of emotional condition and of need for confinement under established standards, the case was remanded to the district court to consider whether individual admissions had met the standards established in the opinion. *Id.* at 617.

It is *amici's* position that while violation of the prohibitions of Section 6010(3) may be enforced by termination of state and fed-

CONCLUSION

For the reasons stated, *amici* respectfully urge the Court to affirm the order of the Court of Appeals and hold that residents of Pennhurst State Hospital, as developmentally disabled people receiving services in a program assisted under the DD Act, have a legally enforceable right under the Act to receive appropriate habilitation services in a setting least restrictive of their civil liberties and that the Commonwealth of Pennsylvania and its counties, having accepting funds under the Act, are obligated to provide those services.

Respectfully submitted,

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eral funding, a violation of Subsection 6063(b)(5)(C) must be rectified by an injunction to specifically enforce the state's affirmative obligations. *See* cases note 23 *supra*; *see also Cannon* v. *University of Chicago*, 441 U.S. 667 (1979); *Regents of the University of California* v. *Bakke*, 438 U.S. 265, 420 n.26 (1978); *Thiboutot* v. *Maine*, 405 A.2d 230, 232 (S. Jud. Ct. Me.), *aff'd* —— U.S. ——, 100 S. Ct. 2502 (1980).

* Counsel for *amici* gratefully acknowledge the invaluable assistance of Alisa G. Field, Legal Intern, Mental Health Law Project.

CERTIFICATION OF SERVICE

I, Margaret F. Ewing, hereby certify that on October 20, 1980, I served by mail one copy of the foregoing Brief for Amici Curiae on David Ferleger, 2321 Sansom Street, Philadelphia, Pa., 19103; Thomas Gilhool, 1315 Walnut Street, Philadelphia, Pa., 19107, and Wade McCree, Solicitor General of the United States, 10th and Constitution Avenues, N.W., Washington, D.C., 20001, Counsel for Respondents, and on Harvey Bartle, III, 16th Floor, Strawberry Square, Harrisburg, Pa., 17120; Alan J. Davis, Suite 1520, Municipal Services Building, Philadelphia, Pa., 19107; Thomas Kittredge, 2107 The Fidelity Building, Philadelphia, Pa., 19109; and Joel I. Klein, 1730 Rhode Island Ave., N.W., Washington, D.C. 20036, Counsel for Petitioners.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
Petitioners,

v.

TERRI LEE HALDERMAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

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Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973, Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare, 93d Cong., 1st Sess. (1973) 7, 8

Mental Health Systems Act, 1979, Hearings Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Labor and Human Resources, 96th Cong., 1st Sess. (1979) 25

S. 1177, 96th Cong., 2d Sess. (1980) 10

126 Cong. Rec. 9,735-36 (July 24, 1980) 10

125 Cong. Rec. H3,637 (May 23, 1979) 10

121 Cong. Rec. 29,821 (1975) 8

121 Cong. Rec. 29,309 (1975) 8

121 Cong. Rec. 9,965; 9,976; 16,514-19 (1975) 11, 26

Page

BOOKS AND ARTICLES:

American Psychiatric Association, "A Position Statement on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded," 134 AM. J. PSYCHIAT. 354 (1977) 16, 17

Bachrach, "A Conceptual Approach to Deinstitutionalization," 29 HOSP. & COMM. PSYCHIAT. 573 (1978) 23

Bachrach, L.L., Deinstitutionalization: An Analytical Review and Sociological Perspective, (National Institute for Mental Health, 1979) 23, 24

Balla, "Relationship of Institution Size to Quality of Care: A Review of the Literature," 81 AM. J. MENTAL DEF. 117 (1976) 20

Baroff, "On 'Size' and the Quality of Residential Care: A Second Look," 18 MENTAL RETARD. 113 (1980).. 20

Bradley, V.J., DEINSTITUTIONALIZATION OF DEVELOPMENTALLY DISABLED PERSONS (1978) 22

Brown & Guard, "The Treatment Environment for Retarded Persons in Nursing Homes," 17 MENTAL RETARD. 77 (1979) 19, 20

Bruininks, *et al.*, "Deinstitutionalization and Community Services," in XI MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (J. Wortis ed. 1980) ..21,23

Coffman & Harris, "Transition Shock and Adjustments of Mentally Retarded Persons," 18 MENTAL RETARD. 9 (1980) 23

Edgerton, "Issues Relating to the Quality of Life Among Mentally Retarded Persons," in THE MENTALLY RETARDED AND SOCIETY: A SOCIAL SCIENCE PERSPECTIVE (M. J. Begab & S. A. Richardson eds. 1975) 24

Edgerton, *et al.*, "The Mental Health Retardation System: Institutional Aspects" in ISSUES IN THE CLASSIFICATION OF CHILDREN: A HANDBOOK OF CATEGORIES, LABELS AND THEIR CONSEQUENCES (N. Hobbs ed. 1975) 22

Ellis, "The Partlow Case: A Reply to Dr. Roos," 5 LAW & PSYCHOLOGY REV. 15 (1979) 20

Page

Eyman & Borthwick, "Patterns of Care for Mentally Retarded Persons," 18 MENTAL RETARD. 63 (1980) 22

Frug, "The Judicial Power of the Purse," 126 U. PA. L. REV. 715 (1978) 15

GAO, *Returning The Mentally Disabled To the Community: Government Needs To Do More* (1977) 24

Hand, "The Spirit of Liberty," in THE SPIRIT OF LIBERTY, PAPERS AND ADDRESSES OF LEARNED HAND (I. Dilliard ed. 1959) 17

Hawks, "Community Care: An Analysis of Assumptions," 127 BRIT. J. PSYCHIAT. 276 (1975) 23

Heal, *et al.*, "Research on Community Residential Alternatives for the Mentally Retarded," in 9 INTERNATIONAL REVIEW OF RESEARCH ON MENTAL RETARDATION (N. Ellis ed. 1978) 22, 23, 24

Hoffman & Foust, "Least Restrictive Treatment of the Mentally Ill: A Doctrine In Search of Its Senses," 14 SAN DIEGO L. REV. 1100 (1977) 27, 28

Justice, *et al.*, "Foster Family Care for the Retarded: Management Concerns for the Caretaker," 9 MENTAL RETARD. 12 (1971) 24

King, R.D., *et al.*, PATTERNS OF RESIDENTIAL CARE: SOCIOLOGICAL STUDIES IN INSTITUTIONS FOR HANDICAPPED CHILDREN (1971) 20

Lamb, *et al.*, "Discharged Mental Patients—Are They Really In the Community?" 24 ARCH. GEN. PSYCHIAT. 29 (1971) 23

McCormick, *et al.*, "Resident Care Practices in Institutions for Retarded Persons," 80 AM. J. MENTAL DEF. 1 (1975) 20

McDevitt, *et al.*, "The Deinstitutionalized Citizen: Adjustment and Quality of Life," 16 MENTAL RETARD. 22 (1978) 21

Mesibov, "Alternatives to the Principle of Normalization," 14 MENTAL RETARD. 30 (1976) 22

Note, "Implementation Problems in Institutional Reform Litigation," 91 HARV. L. REV. 428 (1977) .. 15

Page

O'Connor, G., Home Is A Good Place (American Association on Mental Deficiency, 1976) 24

IV Task Panel Reports To the President's Commission on Mental Health (1978) 24

Roos, "Custodial Care for the 'Subtrainable'—Revisiting An Old Myth," 5 LAW & PSYCHOLOGY REV. 1 (1979) 21

Scheerenberger, "A Study of Public Residential Facilities," 14 MENTAL RETARD. 32 (1976) 19, 22

Scheerenberger & Felsenthal, "Community Settings for MR Persons: Satisfaction and Activities," 15 MENTAL RETARD. 3 (1977) 21

"The Plight of the 'Deinstitutionalized' Mental Patient," 200 SCIENCE 1366 (1976) 25

Slovenko & Luby, "On the Emancipation of Mental Patients," 3 J. PSYCH. & LAW 191 (1975) 25

Talbott, "Deinstitutionalization: Avoiding the Disasters of the Past," 30 HOSP. & COMM. PSYCH. 621 (1979) 23

Tarjan, *et al.*, "Natural History of Mental Retardation: Some Aspects of Epidemiology," 77 AM. J. MENTAL DEF. 369 (1973) 22

Throne, "Deinstitutionalization: Too Wide a Swath," 17 MENTAL RETARD. 171 (1979) 19

Tizard, *et al.*, "Environmental Effects on Language Development: A Study of Young Children in Long-Stay Residential Nurseries," in ANNUAL PROGRESS IN CHILD PSYCHIATRY AND CHILD DEVELOPMENT, 1973 (S. Chess & A. Thomas eds. 1974) 20

Wolfensberger, W., Nirje, B., *et al.*, THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES (1972) 22

Zigler & Balla, "Impact of Institutional Experience on the Behavior and Development of Retarded Persons," 82 AM. J. MENTAL DEF. 1 (1977) 20, 22

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

Nos. 79-1404, 79-1408, 79-1414,
79-1415 and 79-1489

PENNHURST STATE SCHOOL AND HOSPITAL, *et al.*,
Petitioners,

v.

TERRI LEE HALDERMAN, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF OF THE AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

INTEREST OF AMICUS CURIAE

The American Psychiatric Association (APA) was founded in 1844 and is the Nation's largest organization of qualified doctors of medicine specializing in psychiatry. Twenty-six thousand of the Nation's approximately 33,000 psychiatrists are members. Psychiatrists bear a major responsibility for evaluating, developing programs for, and caring for the developmentally disabled.

APA has previously participated as *amicus curiae* in numerous cases involving mental health issues, including *Parham* v. *J.R.*, 442 U.S. 584 (1979); *Addington* v. *Texas*, 441 U.S. 418 (1979); and *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975). The instant case presents the important questions of whether the developmentally disabled have an enforceable statutory right to habilitation, and if so, in

what types of facilities that right must be realized. The Court's resolution of these issues will have a significant impact upon the patients and the professional practice of APA members. *Amicus* believes that its clinical experience and insight concerning the developmentally disabled can assist the Court in shaping its resolution of this case.

CONSENT OF THE PARTIES

APA is filing this brief *amicus curiae* with the consent of all parties, whose letters agreeing to its participation have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

APA believes that the DD Act did confer enforceable rights upon developmentally disabled persons. Whatever rights were conferred by Congress and are to be defined by this Court should in fact serve those patients' interests. Based on its members' clinical experience, APA is convinced that while "deinstitutionalization" into community settings is best for many developmentally disabled patients, for others, institutional settings are most habilitating. More than half the institutionalized developmentally disabled are multiply handicapped; others exhibit grave behavioral disturbances. In some cases, only a facility with a complex array of services and staff training can care for their needs and foster habilitation. "Institutions" are not *per se* inferior to "community" settings; indeed, the professional literature shows a very equivocal relation between institutional size and quality of care. Thus, the key concern in defining the right of the developmentally disabled to habilitation should not be the polemical debate over labelling facilities, but the quality of care provided to patients.

The right to habilitation in the "least restrictive environment" has never been construed to be, and cannot be, an absolute right irrespective of other considerations. "Restrictiveness" is not a unitary concept for all patients, or even for a given patient at all times. In the interests of habilitation, trade-offs must be made among physical con-

straints, drug therapies, or other techniques, sometimes of short duration, and the opportunity they may provide for long-term improvements in life capacities. In sum, we believe that developmentally disabled patients have a right to habilitation in a setting which is *not unnecessarily restrictive of liberties and is most conducive to habilitation.*

APA submits that this is precisely the right which was intended by Congress in the DD Act and was recognized by the Court of Appeals in this case. As both the language and legislative history of the DD Act demonstrate, Congress did not intend that all patients be removed from institutions. The District Court ruled, erroneously we believe, that "institutions" for the mentally retarded would always be incapable of fostering habilitation, and are therefore unconstitutional. 446 F. Supp. 1295, 1318-20. The Court of Appeals, however, did not reach the constitutional issue. It ruled only that the DD Act expressed a "preference for deinstitutionalization" and "did not anticipate a shutdown of all institutions." 612 F.2d 84, 104, 114. It also concluded that there is a right to the "least restrictive setting consistent with that individual's habilitative needs." 612 F.2d at 104. The Court of Appeals' ruling is correct and this Court should endorse it, without being constrained to address the added, conjectural conclusions of the District Court.

The DD Act clearly had two, co-equal purposes: not only providing financial assistance to programs for the developmentally disabled, but also the "Establishment and Protection of the Rights of Persons With Developmental Disabilities." Pub. L. No. 94-103, Title II. The operative language of the statute is equally forthright: "Persons with developmental disabilities have a right to appropriate treatment. . . ." 42 U.S.C. § 6010. In 1978 amendments to the DD Act, Congress underscored its intention that this right be "in addition to any constitutional or other rights otherwise afforded" by law. Pub. L. No. 95-602, § 507. Surely Congress was not blithely talking of apples being added to oranges. As it knew and fully intended, the DD Act granted

rights which were enforceable just like all "constitutional or other rights." The legislative history unequivocally shows this, and subsequent Congressional actions have confirmed it.

Under the Court's recent ruling in *Maine* v. *Thiboutot*, 100 S. Ct. 2502 (1980), Section 1983 actions may be brought to enforce rights secured by any federal law, including the DD Act. Thus, this issue is settled. Moreover, even under the reasoning of the dissenters in *Thiboutot*, Section 1983 actions may properly be brought to enforce rights under a law "providing for equal rights." The DD Act is such a law. It was enacted "to provide equal protection under the law to all citizens," by ensuring "the humane care, treatment, habilitation and protection of the mentally retarded." S. Rep. No. 160, 94th Cong., 1st Sess. 32 (1975). The legislative history articulates several practical and policy reasons why Congress desired that the DD Act not be enforced exclusively by threat of the "atom bomb" of a statewide cutoff of federal funds.

Finally, despite the Petitioners' dire warnings, this appeal presents no issues of judicial excess or challenges to federalism. The Court of Appeals in essence approved two actions of the District Court: (1) ordering that there be a "presumption" in favor of placing Pennhurst residents in community facilities, but that Pennhurst be "improved so as to provide adequate habilitation," and (2) appointing a Master to prepare plans for these actions "taking into account available resources." 612 F.2d at 111, 115, 116. Each of these actions was well within the proper bounds of judicial relief. *Milliken* v. *Bradley*, 433 U.S. 267 (1977); *Swann* v. *Charlotte-Mecklenburg Board of Education*, 402 U.S. 1 (1971). No Eleventh Amendment issue is presented, since any necessary expenditures would be ancillary to "prospective injunctive relief." *Edelman* v. *Jordan*, 415 U.S. 651 (1974). Finally, Petitioners' warning against "embroiling" the federal courts in dictating appropriate care for some future patient who may challenge the setting in which he is placed is unwarranted. Petitioners ask the

Court to rule in advance, by conjecture rather than upon a record, on issues it cannot now properly decide.

ARGUMENT

I. THE DD ACT DOES GRANT RESIDENTS OF STATE INSTITUTIONS FOR THE MENTALLY RETARDED A RIGHT TO HABILITATION

A. The Language, Structure and Purposes of the DD Act

Lawyers and courts alike should guard against the peril of searching for nuances while overlooking the obvious truth. The very name which Congress gave to the DD Act —"The Developmentally Disabled Assistance and Bill of Rights Act"—clearly states its twin purposes: providing financial assistance to state programs *and* the "Establishment and Protection of the Rights of Persons With Developmental Disabilities."[1] This choice of title was not accidental. The prior legislation, the "Developmental Disabilities Services and Facilities Construction Act," Pub. L. No. 91-517, had granted financial assistance but contained no Bill of Rights. However, when Congress enacted the DD Act, it had an additional purpose in mind, and it so indicated.[2]

The operative provisions of the DD Act are equally clear. Section 6010(1) states that "Persons with developmental disabilities have a right to appropriate treatment, services, and habilitation." Section 6010(4) dovetails by providing that "All programs for persons with developmental disabilities should meet standards which," *inter alia,* "protect their rights." Among the "rights" are those conferred in Section 6010(1). *See also* 42 U.S.C. 6063(b)(5)(C). Indeed, Congress became concerned that these provisions might be narrowly construed to encompass *only*

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[1] Pub. L. No. 94-103, Title II, 42 U.S.C. § 6010, *et seq.*

[2] *See* S. Rep. No. 94-160, *supra,* at 1. Congress later reenacted the Bill of Rights title as part of Pub.L. No. 95-602 ("1978 Amendments").

the statutory rights conferred in the DD Act or other federal laws, and not the increasingly recognized constitutional rights of developmentally disabled persons. Therefore, in the 1978 Amendments to the DD Act, it added to Section 6010 the provision that the rights therein "are in addition to any constitutional or other rights otherwise afforded to all persons." This provision would be meaningless unless the DD Act had in fact conferred some rights.

Congress' repeated, deliberate references to the *rights* granted in the DD Act refute the Petitioners' assertion that the DD Act is only a "funding statute, seeking to encourage state efforts to improve care," or that the Bill of Rights is "nothing more than a statement of federal policy." Brief for Petitioners at 10, 7. Such a view is fanciful. In this litigious age, Congress is well aware that its every enactment will be the subject of litigation; it does not dispense "rights," much less codify a "Bill of Rights," frequently or indiscriminately. When Congress wishes to utter no more than a toothless declaration of "federal policy," it does so by commissioning a report, or by a resolution. The operative provisions of bills when enacted are law and Congress knows this. As this Court pointed out in *Cannon* v. *University of Chicago*, 441 U.S. 677, 696-97 (1979), "It is always appropriate to assume that our elected representatives . . . know the law," and "its modes of enforcement."

Alternatively, Petitioners argue that the rights provided in the DD Act were intended to be "rights" only in the sense that if violated, federal funds would be forfeited.[3] However, Congress has enacted many funding statutes for social programs without characterizing the services or benefits provided thereunder as a "Bill of Rights." And

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[3] Had Congress intended such a result, the repeated references to "rights" would have been an implausibly ironic locution. If such "rights" of the developmentally disabled were violated, federal funding would be cut off, and institutional conditions might worsen rather than improve.

when Congress has desired simply to erect conditions to the receipt of federal funds, it has done so in terms. The DD Act itself contains several requirements, each of which is a "condition of providing assistance under this chapter," 42 U.S.C. § 6005, or "a condition to a State's receiving an allotment." 42 U.S.C. § 6011. The "Bill of Rights" was not merely a grandiloquent restating of such a condition.

B. The Legislative History of the DD Act

The proponents of the DD Act were quite aware that it went beyond preexisting legislation which merely financed facilities and services, and that it *codified the rights of patients* which were being defined piecemeal by the courts. In introducing the bill which he co-sponsored, Health Subcommittee Chairman Kennedy began by noting that while the prior legislation had "raised the hopes not only of the developmentally disabled, but of their families and friends," nevertheless, the modesty of funding and improvements in institutional care under the legislation had been "disheartening." He declared that the new legislation would help remedy this, since "The bill of rights of the mentally retarded focuses on the establishment of standards for residential facilities."[4]

Likewise, the major sponsor of the Senate bill, Sen. Javits, said that the deliberations "reflect the continuing deep concern of all the members of the Committee on Labor and Public Welfare to provide improved services and insure equal rights for the mentally retarded." After referring to the terrible conditions at the Willowbrook Developmental Center in New York, he said:

> "I personally viewed the tragedy of Willowbrook . . . and pledged myself to the introduction of a bill of rights for the mentally retarded. . . . [It] would for the first

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[4] Developmental Disabilities Act Extension and Rights of Mentally Retarded, 1973, Hearings Before the Subcomm. on the Handicapped of the Senate Comm. on Labor and Public Welfare, 93d Cong., 1st Sess. 227-28 (1973).

> time establish strict high quality standards to protect the human rights of the mentally retarded . . . ."[5]

In the hearings before the Senate Labor and Public Welfare Committee, whether there would be a binding, enforceable Bill of Rights was a key issue. In reporting the bill to the full Senate, the Committee expressed its "increasing concern" over the plight of the institutionalized mentally disabled and noted that "all too often State legislatures have not adequately funded those institutions." S. Rep. No. 94-160, *supra*, at 2, 28. It specifically referred to the conditions at institutions such as Willowbrook and Partlow, to the right to habilitation asserted in several seminal cases, and to the testimony of those who urged a strong statutory Bill of Rights. Immediately thereupon, it concluded:

> "The Committee is firmly convinced that Congress must take action to ensure the humane care, treatment, habilitation and protection of mentally retarded and other persons with developmental disabilities. The Federal Government has the responsibility to provide equal protection under the laws to all citizens." *Id.* at 32.[6]

The Conference Report—which remains the definitive statement on Congressional purpose—states:

> "The conference substitute contains a compromise which enumerates . . . the rights of persons with developmental disabilities. . . . [It includes] findings that

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[5] *Id.* at 230. Sen. Williams noted that "Of critical importance [is the Bill of Rights which would] . . . establish for the first time in federal law a basic statement of findings of the Congress of the rights of developmentally disabled persons, including . . . a right to appropriate treatment." 121 Cong. Rec. 29,821 (1975).

[6] The House bill originally contained no Bill of Rights title. However, the House agreed to the present Bill of Rights as a compromise with the far more detailed original Senate version. As House Conferee and Health Subcommittee Chairman Rogers said in recommending passage, "[in lieu of] the Senate's very long second title, we were able to get them to agree to a much shorter version" which nevertheless gave a firm "statement of the rights of the developmentally disabled to appropriate treatment and care." 121 Cong. Rec. 29,309 (1975).

> the developmentally disabled have a right to appropriate treatment . . . in the setting that is least restrictive to his personal liberty. . . .
>
> [T]his right should be protected and assured by the Congress and the courts." H.R. Conf. Rep. No. 473, 94th Cong., 1st Sess. 41-42 (1975).

Thus, it would be inappropriate for the Court now to eviscerate even the condensed Bill of Rights which the Senate and House hammered out as a compromise, and which formed the basis on which the legislation was enacted.[7]

C. Subsequent Congressional Confirmation That the DD Act Had Conferred Rights

Had its language and legislative history left any doubt that the DD Act was intended to confer rights, Congress' subsequent actions have removed any such doubt. As we have noted, in the 1978 Amendments, Congress declared that the rights conferred in the DD Act "are in addition to any constitutional or other rights." More recently, the deliberations on the Civil Rights of Institutionalized Persons Act, Pub. L. No. 96-247, demonstrated that Congress not only understood that the DD Act had conferred rights, but was concerned that these rights were not being vigorously enforced. This law authorizes the Attorney General to sue for injunctive relief to end "egregious or flagrant conditions" which deprive institutionalized persons of rights "secured or protected by the Constitution or laws of the United States." 42 U.S.C. § 1997a. The DD Act was recognized as just such a law. The Justice Department's witness, in describing the kinds of suits the Attorney General would bring under the law, specifically mentioned the *Pennhurst* litigation, and noted that the DD Act established "legal rights to care and treatment for the developmentally disabled," and that these "federal statutory rights

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[7] The dissenters on the Third Circuit did not disagree with the majority on the question of whether the DD Act conferred rights. Indeed, they stressed that "Those rights which are conferred by this Act are important and a significant step on the road on which our nation has a far way to go." 612 F.2d at 117.

. . . are being violated on such a systematic and widespread basis as to warrant the attention of the federal government." [8] The Senate and House Reports on the legislation, as well as the comments of various Congressmen, also acknowledged that it would be used to enforce, *inter alia*, rights under the DD Act.[9]

In a recent Report on the proposed Mental Health Systems Act (S.1177), the same Senate Labor and Human Resources Committee which drafted the DD Act clearly stated its understanding that the DD Act had conferred enforceable rights. The bill then under consideration unambiguously granted mental patients rights including "the right to appropriate treatment," which applied whether or not federal funds were received by the facility, and which were enforceable by private suits. The Senate Report on this bill stated that "The Developmental Disabilities [Act] . . . establishes a bill of rights and advocacy system for developmentally disabled citizens. Title III of this bill provides *similar protections* for citizens receiving mental health care." S. Rep. No. 712, 96th Cong., 2d Sess. 35 (1980) (emphasis supplied).[10] Congress later altered the bill, but whether or not it is wise to do so in other statutes, Congress recognized that in the DD Act it did confer significant rights.

II. THE RIGHT TO HABILITATION UNDER THE DD ACT IS ENFORCEABLE BY A PRIVATE ACTION UNDER SECTION 1983

In *Maine* v. *Thiboutot, supra,* this Court recently ruled that 42 U.S.C. § 1983 provides a private right of action

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[8] Civil Rights of Institutionalized Persons, Hearings Before the Subcomm. on the Constitution of the Senate Judiciary Comm., 95th Cong., 1st Sess. 27 (1977).

[9] *See* S. Rep. No. 416, 96th Cong., 1st Sess. 18-20 (1979); H.R. Rep. No. 80, 96th Cong., 1st Sess. 17-18 (1979); 125 Cong. Rec. H3637 (May 23, 1979) (remarks of Rep. Railsback).

[10] *See also* 126 Cong. Rec. S9735-36 (July 24, 1980) (remarks of Sen. Javits).

to redress deprivations of rights not only under the Constitution, but also under any "laws" of the United States, in short, that Section 1983 "means what it says." 100 S. Ct. at 2504. Petitioners now gainsay this very holding, apparently believing that the Court does not mean what it says. But even the dissenters agreed that Section 1983 would doubtless apply to claims which "arise under laws providing for the equal rights of citizens." *Id.* at 2513. As the dissent acknowledged, *Id.* at 2520-21, the DD Act is just such a law.[11] *See also Naughton* v. *Bevilacqua,* 458 F. Supp. 610 (D.R.I. 1978), *aff'd on other grounds,* 605 F.2d 586 (1st Cir. 1979).

In arguing against the clear purpose of the DD Act and the Court's unambiguous opinion in *Thiboutot,* Petitioners cite few cases, none of which is relevant.[12] They then employ two back-up arguments. First, they assert that even if Congress did confer rights in the DD Act, it intended a funding cutoff by the Secretary of Health and Human Services to be the exclusive remedy. In fact, however, Congress contemplated that the developmentally disabled would have recourse to the courts to enforce the Bill of Rights. *See, e.g.,* H.R. Conf. Rep. 94-473, *supra,* at 42 (patients' "right to receive appropriate treatment . . . should be protected and assured by Congress *and the courts*") (emphasis supplied); 42 U.S.C. § 6012(a) (advocacy system is to

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[11] *See* S. Rep. No. 94-160, *supra,* at 32; H.R. Rep. No. 1188, 95th Cong., 2d Sess. 7 (1978); 121 Cong. Rec. 9,965; 9,978; 16,514-19 (1975).

[12] *See* Brief for Petitioners at 28-29. For example, in *Chapman* v. *Houston Welfare Rights Organization,* 441 U.S. 600, 621 (1979) the Court simply found that, unlike the DD Act, the "Social Security Act does not deal with the concept of 'equality' or with the guarantee of 'civil rights.'" In *Adickes* v. *S. H. Kress & Co.,* 398 U.S. 144, 150 n.5 (1970), the Court merely noted in passing that Section 1983 would not be available to redress solely violations of rights for which Congress had provided another, exclusive remedy. Finally, in *Preiser* v. *Rodriguez,* 411 U.S. 475 (1973), the Court found that a prisoner's claim was based on rights which were not among those contemplated by Section 1983, and which were traditionally protected by a habeas corpus petition.

pursue "legal, administrative and other appropriate remedies"); 45 C.F.R. § 1386.70.

Second, Petitioners argue that private suits would be inconsistent with "federal-state cooperation" under the DD Act. Congress believes otherwise. Both in enacting the DD Act, and in other legislation, Congress has viewed private litigation as a necessary adjunct to administrative enforcement of rights. For example, in authorizing grants of attorneys fees in certain civil rights cases (42 U.S.C. § 1988), it was noted that even though administrative remedies were available, "All of these civil rights laws depend heavily upon private enforcement . . . [in order to] vindicate the important Congressional policies which these laws contain." S. Rep. No. 1011, 94th Cong., 1st Sess. 2 (1976). As this Court has noted concerning Title IX, 20 U.S.C. §§ 1681 et seq., which like the DD Act provides for a funding cutoff for noncompliance, nevertheless "many members [of Congress] felt that private enforcement . . . was entirely consistent with, and even necessary to, the enforcement of Title IX and the other statutes." *Cannon* v. *University of Chicago, supra,* 441 U.S. at 686 n 7. *See also Lau* v. *Nichols,* 414 U.S. 563 (1974); *NAACP* v. *Medical Center, Inc.,* 599 F.2d 1247, 1254 (3d Cir. 1979).[13]

There are valid practical and policy reasons why Congress did not intend a funding cutoff to be the exclusive remedy under the DD Act:

> "The enforcement of individual rights, however, cannot be achieved solely by withholding federal funds; not only is the Secretary incapable of investigating every violation, but the Secretary may quite properly be unwilling to withhold funds for a single violation. Thus, the advocacy agency and a private right of action are crucial to protect the rights secured by the Act." *Naughton* v. *Bevilacqua, supra,* 458 F. Supp. at 616.

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[13] As the Court of Appeals noted, "We see in the DD Act . . . more concern for the handicapped than for federal-state relations. Congress must be aware . . . that a litigation program intended to strengthen the rights of mentally retarded persons is an on-

As the Court noted in *Cannon* v. *University of Chicago*, *supra*, 441 U.S. at 677, permitting private actions may limit rather than increase the federal intrusions into state operations. Private suits are tried before local judges and juries. But if suits are not provided for, and the sole remedy is a total cutoff of federal funds for even one violation of rights, then the Department of Health and Human Services will be more deeply involved in monitoring each institution, and local administrators will quake over its every inquiry.

In sum, Petitioners entirely fail to meet the heavy burden of showing "a clear indication in a particular statute that its remedial provisions are exclusive." *Chapman* v. *Houston Welfare Rights Organization*, *supra*, 441 U.S. at 672 (White, J., concurring).

III. THIS APPEAL PRESENTS NO SUBSTANTIAL OR NOVEL ISSUES OF FEDERALISM

There is nothing in the Court of Appeals' ruling to raise the dire perils of judicial usurpation, breakdown in federalism, and fiscal ruin of which the Petitioners warn. The Court of Appeals merely affirmed two rulings of the lower court. *First*, it agreed that there should be "a presumption in favor of placing individuals in [community settings]" and that if Pennhurst was to be used for some patients, "it must be dramatically improved so as to provide adequate habilitation." 612 F.2d at 115-16. *Second*, it approved appointing a Master to prepare plans "for the transfer of Pennhurst residents to [community settings] . . . taking into account available resources," and "for the interim operation of Pennhurst." *Id.* at 111. Neither of these steps was improper. Therefore, it is important to bear in mind precisely what issues are, and are not, in dispute.

First, as the District Court found, "all parties to this litigation are in agreement that Pennhurst as an institu-

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going Justice Department activity. It has not reacted negatively." 612 F.2d at 91 n.7. On the contrary, it enacted Pub. L. No. 96-247, *supra*, to strengthen enforcement.

tion is inappropriate and inadequate for the habilitation of the retarded." 446 F. Supp. at 1304. Pennsylvania intended to close Pennhurst and to transfer all the residents to other facilities in the next few years anyway. *Id.* at 1313. *Second,* both the Court of Appeals majority and the dissenters agreed that sufficient community facilities did not exist and that therefore care in Pennhurst should be upgraded. The Court of Appeals did not rule on the speculative question whether "Pennhurst could *never* provide adequate habilitation because of its very status as a large institution." 612 F.2d at 113. *Third,* it was conceded that "Comparable facilities in the community are generally less expensive than large isolated state institutions." 446 F. Supp. at 1312. *Fourth,* the District Court gave the Petitioners several opportunities to submit an adequate plan before invoking the aid of a Master. 612 F.2d at 90. *Fifth,* as the dissent in the Court of Appeals acknowledged, this case leaves "for future cases, the questions of whether a particular individual in an institution free of deplorable conditions in the record here would ever have a constitutional right to a treatment in a different environment," or "whether a given method of treatment is rationally related to the state's objective in confining a particular individual." *Id.* at 129-30. In light of these unchallenged facts, this case presents none of the issues of federalism which the Petitioners invoke or which the dissent in the Court of Appeals discussed. This Court should not decline to affirm the limited rulings which the Court of Appeals did make merely because future questions might arise as to rulings which it did not make.

It is well settled that "Once a right and a violation have been shown, the scope of a district court's equitable powers to remedy past wrongs is broad, for breadth and flexibility are inherent in equitable remedies." *Swann* v. *Charlotte-Mecklenburg Board of Education,* 402 U.S. 1, 15 (1975). *Accord, Hutto* v. *Finney,* 437 U.S. 678, 687 (1978); *Milliken* v. *Bradley,* 433 U.S. 267, 281-82 (1977). *See generally Jones* v. *Wittenberg,* 330 F. Supp. 707 (N.D. Ohio 1971), *aff'd sub nom. Jones* v. *Metzger,* 456 F.2d 854 (6th Cir. 1972). As the

Court said in *Hills* v. *Gautreaux,* 425 U.S. 284, 297 (1976), the finding of a violation "provided the necessary predicate for the entry of a remedial order . . . and, indeed, imposed a duty on the District Court to grant appropriate relief."

Nor does this case adumbrate Eleventh Amendment problems. As the Court held in *Edelman* v. *Jordan,* 415 U.S. 651, 668, 677-78 (1974), the Eleventh Amendment does not bar a court from granting "prospective injunctive relief" which requires the expenditure of state funds as an "ancillary" measure, that is, "as a necessary consequence of compliance in the future." *See also Quern* v. *Jordan,* 440 U.S. 332 (1979); *Hutto* v. *Finney, supra,* 437 U.S. at 690 n.15; *Fitzpatrick* v. *Bitzer,* 427 U.S. 445 (1976). In fact, many courts have granted relief requiring the expenditure of funds. *See* the copious cases cited in Frug, "The Judicial Power of the Purse," 126 U. Pa. L. Rev. 715, 718-19, 724-25 (1978).

Likewise, courts have increasingly and properly resorted to the use of special masters in order to effectuate the detailed relief necessary to vindicate complex rights. *See, e.g., Chicago Housing Authority* v. *Austin,* 511 F.2d 82 (7th Cir. 1975); *Hart* v. *Community School Board,* 383 F. Supp. 699 (E.D.N.Y. 1974), *aff'd,* 512 F.2d 37 (2d Cir. 1975); *Michigan Association For Retarded Citizens* v. *Smith,* 475 F. Supp. 990 (E.D. Mich. 1979); *Davis* v. *Watkins,* 384 F. Supp. 1196 (N.D. Ohio 1974); *Morales* v. *Turman,* 383 F. Supp. 53 (E.D. Tex. 1974); Note, "Implementation Problems in Institutional Reform Litigation," 91 Harv. L. Rev. 428 (1977).

The relief approved in this case was precedented and proper.

IV. THE RIGHT TO HABILITATION REQUIRES THAT AN EFFORT BE MADE TO SECURE FOR EACH PATIENT A SETTING WHICH DOES NOT UNNECESSARILY RESTRICT LIBERTIES AND IS MOST CONDUCIVE TO HABILITATION

The District Court found that institutionalized retarded persons have a constitutional right to "minimally adequate

habilitation under the least restrictive conditions consistent with the purposes of the commitment," namely each "individual's habilitative needs." 446 F. Supp. at 1319. With this holding, APA agrees.[14] However, the District Court also speculated that habilitation could never be provided "in an institution such as Pennhurst," and that therefore it had to be closed. *Id.* at 1318. In this respect, the District Court was misguided. The Court of Appeals did not reach the constitutional issue, but ruled that "the DD Act provides the mentally retarded with a right to treatment or habilitation," which must be satisfied in "the least restrictive environment." 612 F.2d at 95, 107. The Court of Appeals did not agree that "Pennhurst could *never* provide adequate habilitation because of its very status as a large institution." *Id.* at 113. It found that while the DD Act "disfavored institutionalization," it "did not prohibit all institutions" so long as "adequate habilitation and living conditions are established." *Id.* at 106, 107. The Court of Appeals therefore vacated that part of the lower court's order closing Pennhurst and remanded the case for "individual determinations" as to the most appropriate setting for each patient. *Id.* at 114.

APA submits that in light of the Court of Appeals' decision, this Court has no need to rule on the constitutional issue or the District Court's conjectural dicta.[15] How-

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[14] In 1976, APA adopted a Position Statement on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded stating that while at that time "the legally enunciated right to treatment applies only to involuntarily committed patients, we as physicians believe that adequate care and treatment should be available to all those requiring it, both in the hospital" whether "voluntarily or involuntarily committed," and "in the community." 134 AM. J. PSYCHIAT. 354 (1977) ("APA Position Statement").

[15] As this Court noted in *Quern* v. *Jordan, supra,* 440 U.S. at 338, "It is, however, the decision of the Court of Appeals and not that of the District Court, which we review at the behest of Petitioner. . . . [Petitioner] insists on tilting at windmills by attacking the District Court's opinion."

ever, should the Court define the contours of the right to habilitation in "the least restrictive environment," we believe it is vital to place that right in a meaningful clinical context. If such a right is to advance rather than imperil the welfare of the developmentally disabled, it must be understood—as the Court of Appeals understood it—as a means to a more important end, habilitation. In our view, a persons's liberties though very important, are not the person's sole, or at times even his primary, interests. This is uniquely so for the retarded. Learned Hand asked "What do we mean when we say that first of all we seek liberty?" He answered in part "freedom from oppression, freedom from want, freedom to be ourselves." [16] The simple fact is that the retarded can be freed from the oppression of their bodily needs and helped to grow within themselves only through the intensive services of others, never by the mere negative rights and passive liberties which are the grist of natural law theorists. Therefore, to measure a patient's setting along the sole and pristine continuum of "restrictiveness" of liberty is bootless. For a retarded person, the truly significant meaning which can be given to the "least restrictive alternative" is the setting which *does not unnecessarily restrict liberties and is most conducive to habilitation.*

It is a cruel but unavoidable fact that many institutionalized retarded persons are multiply handicapped, also suffering from blindness, deafness, cerebral palsy, epilepsy, or other disorders. For patients such as these, a program of habilitation may well require a complex array of professional services—including not only good care and medical treatment, but also language or speech therapy, physical therapy, feeding, behavior training, and occupational therapy— which often are available only in institutional settings. Other patients are so agitated, self-abusive or violent or otherwise present such behavioral difficulties that some

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[16] Hand, "The Spirit of Liberty," in THE SPIRIT OF LIBERTY, PAPERS AND ADDRESSES OF LEARNED HAND 142-43 (I. Dilliard ed. 1959).

restrictions or intensive therapy are needed. APA strongly defends the right of such patients to institutions, as well as the humaneness of their being served there.

This position is in no sense an apology for inhumane institutions. In our view, if the right to habilitation is recognized, comparable high quality, humane care and habilitation must be provided regardless of whether or not it is in a setting deemed an "institution." *See* APA Position Statement.

The choice of setting is especially important for mentally retarded individuals since theirs is a chronic condition and institutional care may well be life-long. However, assuming that the legal obligations to improve facilities are met, APA submits that state institutions should remain available as an option for appropriate patients. In recognizing this, the Court of Appeals decision is medically responsible, since it calls for an individualized assessment of each patient's needs, and is not impractical or unduly intrusive, since it does not imply the closing of all institutions. It does not impose a uniform, federal rule. The makeup of the developmentally disabled population, clinical practice, and the extent of community services may vary in different locales. However, this approach does require—as Congress indubitably intended—that alternatives to institutions be created, and that all facilities meet at least the "minimum standards" necessary to "habilitation." 42 U.S.C. § 6010.

A. The Clinical Meaning of "Least Restrictive Alternative": Institutions Are Least Restrictive and Most Habilitating for Some Patients

1. *There Is No Neat Dichotomy Between "Institutions" and "Community Settings"*

Far too much of the debate over the rights of the mentally disabled has revolved around the effort to discredit "institutionalization." Yet, for those familiar with care

settings, affixing labels is the beginning rather than the end of the inquiry. As one commentator has observed:

> "The distinction between institutions and communities is a false one. A human community is composed of people and their institutions. . . . Small and medium-sized community-based residential facilities, group homes, and foster homes are institutions, too. . . . The issue is not one of institutionalization versus deinstitutionalization. . . . The issue is what kinds of institutions best serve. . . ." Throne, "Deinstitutionalization: Too Wide a Swath," 17 MENTAL RETARD. 171 (1979).

"Institution" is a largely meaningless term in light of the vast disparities in size and quality of care exhibited within both the category of settings called "institutions" and the category not so identified. For example, one exhaustive study of "public residential facilities" in the United States found that they ranged in bed capacity from 10 to 3,178, with a median of 649. But while facilities built before 1964 had a median bed capacity of 1,014, those built after 1964 had a median capacity of 318 beds. The author noted that newer institutions generally have "low rated bed capacities," and "a wide variety of programming," and that "staffing patterns" and "the quality of residential care . . . appear to be improving." Scheerenberger, "A Study of Public Residential Facilities," 14 MENTAL RETARD. 32, 35 (1976). Another study noted that even within a category such as nursing homes, the quality of care varied greatly "according to proportion of supervisory personnel, proportion of retarded patients, extent of staff approval of admitting retarded patients, and extent of patient and family inclusion in planning treatment." Brown & Guard, "The Treatment Environment for Retarded Persons in Nursing Homes," 17 MENTAL RETARD. 77, 80-81 (1979).

Several studies have evaluated whether there is in fact any empirical correlation between the size of the facility alone and the quality of care afforded patients. The results have almost invariably been equivocal. One review of the major studies concluded that within four types of residen-

tial settings ranging from small group homes to large institutions, while "care practices were more resident-oriented, that is more individualized, in the smallest of the residential settings, the group homes," overall "size was unrelated to resident vs. institution oriented care practices. What we have then is the curious finding that size is and is not important." The author also noted that large institutions generally have more patients who are extremely retarded and that this often requires them to adopt more restrictive or structured care regimes. Baroff, "On 'Size' and the Quality of Residential Care: A Second Look," 18 MENTAL RETARD. 113 (1980).[17]

Another study concluded that "[s]ize of institution had little effect on either autonomy or activity level of the home," and that "the relation between care practices and size of institution is spurious." Brown & Guard, *supra*, at 79-80. Different types of facilities may be more effective in addressing some but not necessarily all of the needs of particular persons.[18] One reviewer has concluded that the literature shows only that "institutions with high quality programs promote development; those of poor quality do not." Ellis, "The Partlow Case: A Reply to Dr. Roos," 5 LAW & PSYCHOLOGY REV. 15, 24 (1979).

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[17] *See also* R. D. KING, *et al.*, PATTERNS OF RESIDENTIAL CARE: SOCIOLOGICAL STUDIES IN INSTITUTIONS FOR HANDICAPPED CHILDREN (1971); McCormick, *et al.*, "Resident Care Practices in Institutions For Retarded Persons," 80 AM. J. MENTAL DEF. 1 (1975).

[18] "[I]n view of the wide variety of institutional settings and . . . their varying effects of development, it is perhaps time to abandon the concept of the 'institution' as a factor in development, and to replace it with a consideration of the effects of different institutional regimens on different aspects of development." Tizard, *et al.*, "Environmental Effects on Language Development: A Study of Young Children in Long-Stay Residential Nurseries," in ANNUAL PROGRESS IN CHILD PSYCHIATRY AND CHILD DEVELOPMENT 1973, 705, 728 (S. Chess & A. Thomas eds. 1974). *See* Zigler & Balla, "Impact of Institutional Experience on the Behavior and Development of Retarded Persons," 82 AM. J. MENTAL DEF. 1 (1977); Balla, "Relationship of Institution Size to Quality of Care: A Review of the Literature," 81 AM. J. MENTAL DEF. 117 (1976).

2. *"Deinstitutionalization" Is Generally Preferable; But the Least Restrictive and Most Habilitating Environment for Some Patients Is in an Institution*

The principles of "normalization" and "community care" of the mentally retarded, properly stated, are well founded in clinical experience. But properly stated what those principles entail is not an absolute rule of deinstitutionalization, but rather, programs based on the premise that "all developmentally disabled people, regardless of the degree of impairment, have potential for growth," and providing care in settings no more restrictive than necessary to achieve habilitation. Bruininks, *et al.*, "Deinstitutionalization and Community Services," in XI MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES 55, 56-57 (J. Wortis ed. 1980). As a guiding principle rather than an iron rule, there is a consensus that community settings are often preferable. Several studies have found in substance that:

> "[A]lternative community facilities presently being utilized are proving most successful in meeting former resident needs and in providing personally gratifying life experiences. . . . [F]ew expressed any desire to return to an institutional setting." Scheerenberger and Felsenthal, "Community Settings for MR Persons: Satisfaction and Activities," 15 MENTAL RETARD. 3, 7 (1977).[19]

However, even the originators of the concept of "normalization" regarded it not as an exclusive basis for evaluating quality of care, but rather as one approach to the paramount goal of habilitation. They agree that "Deviation from normative environments has been justified if it proves more successful . . . in increasing the individual's control over his environment, or in releasing staff from time-consuming routine functions which interfere with meaningful

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[19] *See also* McDevitt, *et al.*, "The Deinstitutionalized Citizen: Adjustment and Quality of Life," 16 MENTAL RETARD. 22, 23 (1978); studies cited in Roos, "Custodial Care for the 'Subtrainable'—Revisiting an Old Myth," 5 LAW & PSYCHOLOGY REV. 1, 10-11 and nn.42-53 (1979).

interaction with trainees." W. WOLFENSBERGER, B. NIRJE, *et al.*, THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES 145-48 (1972). Thus, "by itself, deinstitutionalization is neither a value nor an end. It is neutral. It is a series of steps that once taken may or may not be beneficial to clients." V. J. BRADLEY, DEINSTITUTIONALIZATION OF DEVELOPMENTALLY DISABLED PERSONS 59 (1978).

As two recent reviewers of the clinical literature have noted, "The assumption made by proponents of deinstitutionalization is that the needs of all MR persons are similar in that they can be met in a community setting, regardless of the severity of problems or unique characteristics which lead to initial placement in institutions." This assumption is incorrect. In fact, institutionalized patients are generally more seriously impaired.[20] Because of the "differences between institutional and convalescent hospital patients," at present, "community resources appear to be insufficient to accommodate all institutionalized residents." Eyman & Borthwick, "Patterns of Care for Mentally Retarded Persons," 18 MENTAL RETARD. 63, 65 (1980).[21]

Finally, from a clinical point of view, one cannot underestimate the difficulty many retarded persons experience in making the transition from institutional settings to community settings. This "transition shock" often "can entail

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[20] Some 74 percent of the Pennhurst residents were profoundly retarded (I.Q. of 20 or less) or severely retarded (I.Q. of 21-35). 446 F.Supp. at 1302. This is not atypical of institutions. *See* Scheerenberger, *supra*; Heal, *et al.*, "Research on Community Residential Alternatives for the Mentally Retarded," 9 INTERNATIONAL REVIEW OF RESEARCH OF MENTAL RETARDATION 209, 219 (N. Ellis ed. 1978).

[21] *See also* Tarjan, *et al.*, "Natural History of Mental Retardation: Some Aspects of Epidemiology," 77 AM. J. MENTAL DEF. 369 (1973); Mesibov, "Alternatives to the Principle of Normalization," 14 MENTAL RETARD. 30 (1976); Edgerton, *et al.*, "The Mental Health Retardation System: Institutional Aspects" in ISSUES IN THE CLASSIFICATION OF CHILDREN: A HANDBOOK OF CATEGORIES, LABELS AND THEIR CONSEQUENCES 62 (N. Hobbs ed. 1975); Zigler & Balla, *supra*.

much disorientation, regression and emotional distress." Coffman & Harris, "Transition Shock and Adjustments of Mentally Retarded Persons," 18 MENTAL RETARD. 3 (1980). Thus, it may well be that "at least some part of the state hospital's role in the spectrum of services is too difficult to replace by alternative settings in all communities—and that the hospital's role should in fact be enhanced through new and innovative programming rather than eliminated." Bachrach, "A Conceptual Approach to Deinstitutionalization," 29 HOSP. & COMM. PSYCHIAT. 573, 576 (1978) ("Bachrach, A Conceptional Approach").

3. *The "Least Restrictive Alternative" Is a Meaningful Concept Only If Quality Care Settings and Support Services Are in Fact Provided in a Community*

"Basic to the recommendation that the mentally ill should be treated in the community is the assumption that the community is therapeutic or that the community cares." Hawks, "Community Care: An Analysis of Assumptions," 127 BRIT. J. PSYCHIAT. 276, 277 (1975). The success of deinstitutionalization depends on—rather than being a separate issue from—the quality of institutional habilitation and preparation for community life. *See,* Bruininks, *supra.* And the "idea of deinstitutionalization" is realistic only if the "community is capable of providing, outside of institutional settings, the full range of patient services that are available inside the hospital." Bachrach, Deinstitutionalization: An Analytical Review and Sociological Perspective (National Institute for Mental Health, 1979) ("Bachrach, Sociological Perspective").

The simple fact is that "community facilities" often are modest entities which have no track record,[22] are not licensed by the state, and are run by untrained, unsupervised individuals whose motives span the human personality. It is not

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[22] *See* Heal, *et al., supra;* Talbott, "Deinstitutionalization: Avoiding the Disasters of the Past," 30 HOSP. & COMM. PSYCHIAT. 621 (1979); Lamb, *et al.,* "Discharged Mental Patients—Are They Really In The Community?" 24 ARCH. GEN. PSYCHIAT. 29 (1971).

surprising, therefore, that "Community-based programs have not been immune to dehumanizing forces." Bachrach, Sociological Perspective at 22. As one study pointed out, caretakers often foster "dependencies" of patients, and there is a common practice of "withholding information about a patient's right to decide for himself or herself whether he or she wants to live in that facility." Edgerton, "Issues Relating to the Quality of Life Among Mentally Retarded Persons," in THE MENTALLY RETARDED AND SOCIETY: A SOCIAL SCIENCE PERSPECTIVE 127, 140 (M. J. Begab & S. A. Richardson eds. 1975).

Moreover, community facilities often are not backed up by the necessary support services, such as counselling, transportation, social and vocational services. Justice, *et al.*, "Foster Family Care for the Retarded: Management Concerns for the Caretaker," 9 MENTAL RETARD. 12 (1971). In a major study on 611 group home facilities, almost 90% of the superintendents reported that one or more community support services was unavailable or inadequate, and nearly half of them reported that four or more such services were unavailable or inadequate. G. O'Connor, Home is A Good Place (American Association on Mental Deficiency, 1976). *See also* the copious studies cited in Heal, *et al., supra,* at 234-38; Bachrach, Sociological Perspective, at 12; IV Task Panel Reports To the President's Commission on Mental Health 2001, 2005 (1978).

As the General Accounting Office reported in 1977 based on its review of community facilities, many of the disabled who have been discharged from institutions "have been placed in crowded, substandard facilities in unsafe neighborhoods, facilities inappropriate to their needs, or facilities without provision for needed services." GAO, *Returning The Mentally Disabled To The Community: Government Needs To Do More,* Summary at 2 (1977).

The unmistakable fact is that in most communities there do not now exist support services adequate to permit deinstitutionalization of all or nearly all institutional resi-

dents. Where transfer to the "community" is undertaken in spite of such a lack of services, the mentally retarded are asked to face the abandonment which has too often befallen the mentally ill.[23]

This Court should not exacerbate this result by erecting an iron rule that all patients—regardless of their needs—must be cared for in community facilities.

B. The Legal Meaning of "Least Restrictive Alternative"

The meaning of "least restrictive alternative" ("LRA") which is sensible in light of the realities of care is also that which was intended by Congress in the DD Act and which has been embraced by the lower courts. The DD Act states that services for a developmentally disabled person should "maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty." 42 U.S.C. § 6010(2). The conjunctive locution and the order in which these goals are stated accurately reflect Congress' views. Congress did not view the doctrine of LRA as so all-consuming that all institutions would be rendered unconstitutional.

On the contrary, the legislative history of the DD Act is replete with acknowledgements that "institutions" would continue to be necessary for some patients. Congress

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[23] As former HEW Secretary Joseph A. Califano, Jr. testified, "For many long-time residents of mental institutions, deinstitutionalization has meant being dumped into communities to live in poorly maintained boarding homes or single room occupancy hotels —often without adequate food, clothing, recreational or social services." Mental Health Systems Act, 1979, Hearings Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Labor and Human Resources, 96th Cong., 1st Sess. 55 (1979). *See also* Slovenko & Luby "On the Emancipation of Mental Patients," 3 J. PSYCH. & LAW 191 (1975) ("Mental patients are going from the frying pan into the fire. Under the guise of civil liberties the state mental hospital has been transported to the inner city . . . [But] in today's world, neglect in the community dwarfs neglect in hospitals"); "The Plight of the 'Deinstitutionalized' Mental Patient," 200 SCIENCE 1366 (1978).

focused primarily on the need to transfer patients who were *inappropriately* placed in institutions, and on upgrading conditions for those who would remain in institutions. For example, the Conference Report on the bill stated that state plans must be designed to "eliminate inappropriate placement in institutions of persons with developmental disabilities, and to improve the quality of care and the state of surroundings of persons for whom institutional care is appropriate." H.R. Conf. Rep. No. 94-473, *supra*, at 33.[24]

In addition, there is nothing in either the origin or history of the doctrine of LRA which in any way places it above other interests of individuals, or compels the closing of institutions. The doctrine of LRA means essentially that there must be a rational relationship between government methods and the ends to be achieved in areas affecting sensitive constitutional rights.[25] It was never intended to

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[24] The House Report noted that projects were funded for "improving conditions within the institutions," and "the improvement of standards and accreditation tools for both inpatient and outpatient services." H.R. Rep. No. 58, 94th Cong., 1st Sess. 7 (1975). The debates contain many similar observations. In introducing H.R. 4005, Rep. Carter stated that among its purposes was "improving the facilities and surroundings where people have been appropriately institutionalized." 121 Cong. Rec. 9,976 (1975). Likewise, in introducing the Senate version, S. 462, Sen. Stafford said that one of its purposes was to protect the rights of "those individuals that will require institutionalization." 121 Cong. Rec. 16,516.

[25] The doctrine of LRA as first conceived meant simply that the Courts would not abide state regulatory schemes which needlessly obstruct interstate commerce, where "reasonably nondiscriminatory alternatives, adequate to conserve legitimate local interests, are available." *Dean Milk Co.* v. *City of Madison*, 340 U.S. 349, 354 (1951). The most relevant provenance for the doctrine of LRA is *Shelton* v. *Tucker*, 364 U.S. 479, 488 (1960), in which the Court struck down an Arkansas statute requiring public school teachers annually to list their organizational affiliations, saying that "[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more

supplant the ends themselves. In the mental health field, the doctrine of LRA is particularly tricky—because at least for the nondangerous mentally retarded, the goals of the state and of the patient ought to be the same—the best habilitation available. Moreover, since there may be "no relationship between restrictiveness and [treatment] effectiveness, let alone a stable or singular one," balancing restrictiveness and efficacy will "require case by case analysis." Hoffman & Foust, "Least Restrictive Treatment of the Mentally Ill: A Doctrine In Search of Its Senses," 14 SAN DIEGO L. REV. 1100, 1103-04 (1977).

The lower courts have construed LRA not as an absolute right, but as applying insofar as it is consistent with the habilitative needs of the patient. For example, in *Davis* v. *Watkins*, 384 F. Supp. 1196, 1203 (N.D. Ohio 1974) the court defined the right to be placed in the "least restrictive setting" as the "minimum limitation of movement or activity" necessary to protect against dangerousness "and in which treatment or habilitation continues to the fullest extent possible." LRA means that decisionmakers must "make good faith attempts to place such persons in settings that will be suitable and appropriate to their mental and physical conditions while least restrictive of their liberties." *Welsch* v. *Likins*, 373 F. Supp. 487, 502 (D. Minn. 1974), *aff'd in part and vacated in part*, 550 F.2d 1122 (8th Cir. 1977).[26] Likewise, some twenty state commitment statutes

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narrowly achieved. The breadth of legislative abridgement must be viewed in light of less drastic means for achieving the same basic purpose."

[26] *See also Naughton* v. *Bevilacqua, supra,* (DD Act requires that an effort be made at "developing the individual's potential to the maximum in the most normal or least restrictive environment possible"); *Eubanks* v. *Clarke,* 434 F. Supp. 1022, 1028 (E.D. Pa. 1977) (in civil commitment "due process requires that the state place individuals in the least restrictive setting consistent with legitimate safety, care and treatment objectives"); *Lynch* v. *Baxley,* 386 F. Supp. 378, 392 (M.D. Ala. 1974) (there must be a showing that "the proposed commitment is to the least

refer to the doctrine of LRA, and to our knowledge, in no state has this been construed to require deinstitutionalization of all patients. See Hoffman & Foust, *supra*, at 1113-14.

Moreover, in the preponderance of cases discussing LRA, the court has been asked to consider what due process requirements were necessary to provide a sufficient "quid pro quo" for involuntary commitment of the mentally ill. But different questions are posed in the care of a mentally retarded child who is voluntarily placed by the family for his/her welfare. As Chief Justice Burger pointed out in his concurring opinion in *O'Connor* v. *Donaldson*, 422 U.S. 563, 587 (1975), the "troublesome feature of the *quid pro quo* theory is that it would elevate a concern for essentially procedural safeguards into a new substantive constitutional right." Whether or not that is appropriate for involuntarily civilly committed adults, for the mentally retarded the right to LRA should not be elevated to the point that it engulfs all other considerations. The decision as to the setting which is least restrictive, most habilitating, and best overall, should be left to physicians working with patients and their families.

This approach is quite similar to that which this Court embraced in *Parham* v. *J.R.*, 442 U.S. 584 (1979). There, the Court decided that where there are competing interests of a child in the protections of due process, and of both the child and his family in securing treatment, a flexible, realistic approach must be taken. The Court noted that "The mode and procedure of medical diagnostic procedures is not the business of judges. What is best for a child is an individual medical decision that must be left to the judgment of physicians in each case." 442 U.S. at 607-08. The child's

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restrictive environment consistent with the needs of the person to be committed"); *Covington* v. *Harris*, 419 F.2d 617, 623 (D.C. Cir. 1969) ("the principle of the least restrictive alternative consistent with the legitimate purposes of a commitment inheres in the very nature of civil commitment").

interests would be satisfied so long as there was a "neutral and detached" medical decision. In the decisionmaking on LRA, a similar standard should be applied, for the determination depends not alone on civil liberties and legal facts, but "on the meaning of the facts which must be interpreted by expert psychiatrists and psychologists." *Addington* v. *Texas,* 441 U.S. 418, 429 (1979).

In APA's view, therefore, the doctrine of LRA prescribes reasonable duties in which patients' interests in treatment and in liberty can be balanced. Petitioners have argued that "Under the decision below, it is the federal courts which will ultimately determine what habilitative services are required for each retarded person's 'maximum development.'" Petition for Writ of Certiorari of the County Petitioners at 16. We do not believe that the Court of Appeals decision leads to this result. It does not create new rights to judicial hearings. It simply requires that the patient, family representative and physician make a determination for each patient as to the best setting. The decision of this group might conceivably be reviewable for malicious deprivation of civil liberties, just as it would be now. But we do not believe that the doctrine of LRA, as defined by the Court of Appeals, and as construed in the manner suggested, need lead to innumerable federal court hearings. The duty of the decisionmaker remains that of making "an earnest effort . . . to review and exhaust available resources of the community in order to provide care reasonably suited to [the patient's] . . . needs." *Lake* v. *Cameron,* 364 F.2d 657, 660-62 (D.C. Cir. 1966).

Thus, Petitioners, in urging the Court to examine and rule on the precise procedural issues which may be posed in some conjectural future proceeding challenging a decision on LRA, or the placement of a particular resident of Pennhurst, are asking the Court to rule, absent a record, upon issues which it cannot and should not now decide.

CONCLUSION

For the foregoing reasons, the American Psychiatric Association, *amicus curiae,* urges (1) that the Court affirm the decision of the Court of Appeals to the extent of declaring that the mentally retarded have a right to habilitation under the DD Act, which is enforceable by a suit pursuant to § 1983, and (2) that any decision of the Court concerning the right to habilitation in the least restrictive environment should make clear that the right is simply one factor to be considered in the effort to place each patient where he can best receive humane care and habilitation.

Respectfully submitted,

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IN THE

Supreme Court of the United States

October Term, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, ET AL.,
Petitioners,

v.

TERRI LEE HALDERMAN, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF FOR CONGRESS OF ADVOCATES FOR THE RETARDED, INC., CALIFORNIA ASSOCIATION OF STATE HOSPITAL PARENT COUNCILS FOR THE RETARDED, NEBRASKA CHAPTER OF MENTAL RETARDATION ASSOCIATION OF AMERICA, INC., PARENT ASSOCIATION FOR THE RETARDED OF TEXAS, THE MENTAL RETARDATION ASSOCIATION OF MISSOURI, INC., PARENTS AND FRIENDS OF CONNECTICUT RETARDED CITIZENS, HOME AND SCHOOL ASSOCIATION OF SOUTHBURY TRAINING SCHOOL, MANSFIELD PARENT'S ASSOCIATION OF THE MANSFIELD TRAINING SCHOOL, BELCHERTOWN STATE SCHOOL FRIENDS ASSOCIATION, FERNALD LEAGUE, PARENTS AND FRIENDS OF MONSON DEVELOPMENTAL CENTER, SUNLAND PARENTS AND FRIENDS, BEATRICE STATE DEVELOPMENTAL CENTER ASSOCIATION, PARENTS ASSOCIATION OF ST. LOUIS STATE SCHOOL AND HOSPITAL, INC., FRIENDS OF RAINEAR, FRIENDS OF FIRCREST, LAKELAND VILLAGE ASSOCIATES, AND FRIENDS OF YAKIMA VALLEY SCHOOL, AS *AMICI CURIAE*

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* OF CONGRESS OF ADVOCATES FOR THE RETARDED, INC., *et al.*

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE

The Congress of Advocates for the Retarded, Inc. ["The Congress"] and the organizations named in paragraph 2 hereof, move for leave to file the attached brief *amici curiae*.[1]

1. The Congress is a national non-profit corporation organized under the laws of the District of Columbia, with more than three thousand members. Each of its officers and directors is a parent or other immediate relative of a retarded individual. Among the purposes of the Congress declared in its charter are "advanc[ing] the interests of mentally retarded persons in achieving appropriate education, housing, medical and other services . . . and, in particular, . . . assur[ing] the continued availability of an appropriate range of institutions and other facilities for the perpetual care, shelter, treatment and education of the mentally retarded. . . ."

2. California Association of State Hospital Parent Councils for the Retarded (CASH-PCR) is a non-profit organization. Each of California's nine state hospitals serving the retarded has a supportive non-profit association composed of parents, relatives, friends and advocates of the retarded residents. The Board of Directors of CASH-PCR includes the President Representative of each of those nine associations. CASH-PCR is engaged in efforts to improve the quality of programs for the retarded both in institutions and in the community. The Nebraska Chapter of the Mental Retardation Association of America, Inc. is a non-profit organization of parents and relatives of mentally retarded people throughout that State. A particular concern of the organization is the lack of adequate care in many

---

[1] All petitioners consented to the filing of this brief, and the respondent United States indicated it expected to consent. But counsel for respondents Terri Halderman, et al. refused to consent unless provided an advance copy of a draft or outline of the proposed brief. Time constraints precluded satisfying that request.

community-based residences for the retarded in Nebraska, and the importance of preserving and improving needed residential institutions. Each of the other *amici* is a non-profit organization of parents, relatives and other advocates of the interests of retarded persons presently residing in particular public institutions. The Parent Association for the Retarded of Texas, the Mental Retardation Association of Missouri, Inc., and the Parents and Friends of Connecticut Retarded Citizens represent the interests of retarded people at state institutions throughout their respective states; and the following *amici* represent the interests of retarded people at the institutions identified in the organizations' names: the Home and School Association of the Southbury Training School and the Mansfield Parent's Association of the Mansfield Training School, both in Connecticut; the Belchertown Friends Association, Fernald League, and Parents and Friends of Monson Developmental Center, all in Massachusetts; the Sunland Parents and Friends, Orlando, Florida; the Beatrice State Developmental Center Association, in Nebraska; the Parents Association of St. Louis State School and Hospital, Inc., in Missouri; and the Friends of Rainier, Friends of Fircrest, Lakeland Village Associates, and Friends of Yakima Valley School, all in Washington.

3. The court below has construed the Developmentally Disabled Assistance and Bill of Rights Act (hereinafter "the Act") to empower the federal courts to transfer retarded persons out of institutions to the "least restrictive environment" in which care can be provided. 612 F.2d at 103-107. And, the court further held that in implementing that power, "the court or Master should engage a presumption in favor of placing individuals in community living arrangements ('CLAs')" rather than in institutions, with institutionalization to be permitted only in an "extreme situation." *Id.* at 115-116.

4. Although couched in terms of a "right," this presumption will result in the removal from institutions of

many retarded people who do not desire removal, and for whom removal is disadvantageous. The decision does not require the consent of a retarded individual, or of his parents or guardian, as a condition to his deinstitutionalization. Retarded people generally lack the capacity for meaningful participation in the judicial proceedings which, under the ruling below, will determine their fates. Consequently, in class litigation of the sort approved below, if a retarded person has no parent or other advocate to contest removal from the institution, the presumption will result in deinstitutionalization even when that course is not desired and is contrary to the individual's interest. Where a retarded person *does* have parents or other advocates who challenge the proposed removal, under the ruling below they will not be able to prevent removal except by participating in individual judicial hearings and battling uphill against the presumption. Given the disagreements among experts in this area, there will be many cases in which the evidence is equivocal, and in such cases the presumption will mandate deinstitutionalization. Finally, the decision below may prompt state and local governments to undertake "voluntarily" an across-the-board movement of retarded people from institutions to CLAs, rather than face protracted litigation in which the advocates of broad-scale deinstitutionalization would enjoy a presumption in their favor.

5. *Amici* recognize the value of community living arrangements for many retarded people, and support efforts to improve all facilities for the retarded, both CLAs and institutions. But *amici* believe that for many (particularly the severely and profoundly retarded and those with multiple handicaps), CLAs are not an appropriate alternative to institutions. *Amici* know first-hand the enormous diversity in the conditions, capabilities, and needs of retarded persons, and they seek to assure the continued availability of a full spectrum of facilities and services from which retarded persons, together with their parents or responsible advocates and professionals, can select the means of habilitation best suited to each individual. By requiring courts

to apply a presumption in favor of one type of facility, the decision below frustrates that objective.

6. *Amici's* brief shows that there is no justification in the Act for creating a presumption in favor of CLAs, a showing which they fear may not be fully presented by the parties who will likely concentrate on the threshhold question whether the "Bill of Rights" provision of the Act (42 U.S.C. § 6010) is judicially enforceable. In addition to discussing the statutory language, structure and history which show that Congress intended no presumption, *amici's* brief presents a balanced view of the state of professional knowledge and opinion regarding the nature of the disabilities suffered by the mentally retarded residents of public institutions, and of the relative capacities of institutions and CLAs to provide the treatment and habilitation they need. This material is important, for it defines the real world about which Congress was legislating, (cf. *United States v. Maher*, 307 U.S. 148, 155) and thus facilitates understanding of the Act's language and purpose.

7. The court of appeals believed that testimony introduced at the trial of this case established the inherent superiority of CLAs over institutions. See 612 F.2d at 93, 113-114. However, all of the litigants apparently desired, albeit for varying reasons, that Pennhurst ultimately be closed (see Pet. App. 135a). None sought to establish the value of institutions as facilities for habilitation. Petitioner Pennhurst Parents-Staff Association wished to correct that defect in the record, but was denied intervention. Thus, on the question here presented the lower courts received only one point of view. As *amici's* brief demonstrates, the result was a slanted perception of the condition, capacities and needs of those retarded persons who presently reside in institutions, a misperception which led the courts to misconceive the intent of Congress.

CONCLUSION

Because *amici* have a substantial interest in this case, and

their brief addresses an important issue before the Court which the parties are not likely to treat in full, this motion for leave to file a brief as *amici curiae* should be granted.

Respectfully submitted,

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> services were provided in a large institution . . . A large residential facility is frequently a self-contained unit that provides its own schools, medical facilities, power, water, waste disposal, roads, etc. . . . [and] operate[s] on a small scale compared to populations given these services in the communities. Facilities located in the community, therefore, will usually be able to purchase these services at a [lower] cost . . . .
>
> . . . .
>
> (2) Since small facilities can be specialized, only those services needed by . . . [the retarded] in each facility need to be provided. In large institutions the retarded are compelled to accept the full range of custodial services.

R. Conley, *The Economics of Mental Retardation,* 356, 357 (1973).

Dr. Conley's findings and conclusions are supported by a study recently undertaken by the State of Nebraska. The Directors of the Departments of Public Institutions and Public Welfare of that state retained Touche Ross & Company to study the costs to serve retarded citizens in the community and in Nebraska's only institution for retarded people, Beatrice State Developmental Center. In particular these consultants were asked to study and address, among others, the following questions:

1. What is the cost of serving clients in Beatrice State Developmental Center (BSDC) and in each of the Community Based Mental Retardation Regions (CBMR)?

2. What is the potential financial impact of the placement of BSDC clients into the CBMR?

The study concludes that, on the average, it is less costly to serve a retarded person in the community than in BSDC. Some of the explanations given for this conclusion include:

1. BSDC, as an institution, has a high proportion of relatively inflexible overhead costs (building maintenance, grounds, utilities, medical, administration, etc.)

2. Community residential programs utilize direct care staff to accomplish home maintenance chores such as cooking and cleaning. Often the CBMR client will participate in these activities as a part of a residential living skills program. BSDC employs over 150 food service and custodial workers in addition to its direct care staff.

3. Community programs integrate high need clients into residential facilities serving predominately moderate need clients without increasing staff.

4. CBMR residential programs have the flexibility to recognize the clients' independent living skills. As a result, the community programs have the opportunity to serve higher skilled, lower need clients in less costly programs. This is not true at the institution.

The study also concludes:

> Thus, not only are current costs per client less in the CBMR [Community Based Mental Retardation] Regions than BSDC [Beatrice State Developmental Center], but also the opportunity exists that costs may be reduced further in the CBMR Regions as clients achieve community living skills.

State of Nebraska, Cost Study of the Community Based Mental Retardation Regions and the Beatrice State Developmental Center, 4 (August 15, 1980).

This same conclusion was also predicted by the State of Michigan's Joint Committee to Study Abuse in State Mental Health Facilities. According to them:

> Although cost effectiveness studies comparing institutional treatment with coordinated community care do not exist, every indication is that, because community placement promotes more rapid movement to higher levels of functioning for mentally retarded persons than does institutional care, costs over the long term should decrease more quickly than for institutional care for a similar period.

Report to the Michigan 79th Legislature, Regular Session of 1978, 7 (December 14, 1978).

Connecticut has offered no support for its assertion that the *Pennhurst* orders will be burdensome on the taxpayers of this state. Indeed, the available data and the findings of the District Court in *Pennhurst*[25] point to the opposite conclusion.

CONCLUSION

For the foregoing reasons *Amici* urge the Court to affirm the decision of the Court below.

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[25] *Halderman* v. *Pennhurst,* 446 F. Supp. 1295, 1312 (1977).

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AMICI CURIAE BRIEF OF ILLINOIS, NEW HAMPSHIRE, LOUISIANA, OHIO, SOUTH DAKOTA, WASHINGTON, WEST VIRGINIA, NEBRASKA, NEW JERSEY, TENNESSEE AND MINNESOTA

INTEREST OF AMICI CURIAE

The States of Illinois and New Hampshire are currently engaged in the development and implementation of comprehensive deinstitutionalization plans concerning the majority of individuals now receiving care in public institutions for the mentally retarded. Both state legislatures have recognized the importance of this effort and substantially increased funding. The goal of that increase is to expand community-based services as well as to improve existing state-operated institutions. It must be stated at the outset therefore, that Amici

do not oppose deinstitutionalization where appropriate, nor do they condone conditions as were found to exist in the Pennhurst State School and Hospital.

In addition, many of the states joining in this amicus brief are defending at this time at least one major lawsuit, some of them class actions, raising the same issues decided by the courts below.[1] The states, therefore, have a very real and substantial interest in this Court's interpretation of the nature, scope and constitutionality of their obligations as participants in the funding scheme promulgated by the Developmentally Disabled Assistance and Bill of Rights Act (hereinafter the "Act"). Without guidance from this Court, the states' mandated long-term planning efforts will continue to be thwarted by the difficulties of reconciling the Act's provisions (and especially the Third Circuit's interpretation thereof) with those of other applicable federal statutes (*e.g.*, Medicaid Act, Title XIX, 42 U.S.C. § 1396 *et seq.;* the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 701 *et seq.;* the Education of the Handicapped Act, 20 U.S.C. § 1401 *et seq.*) and the United States Constitution.

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[1] The State of New Hampshire completed a ten-week trial on these issues in June 1980 and is awaiting a decision thereon by the federal district court. Garrity v. Gallen, C.A. No. 78-116 (D.N.H.). Cases involving other states include: *Illinois Association for Retarded Citizens, et al.* v. *Governor James Thompson, et al.*, 80-C-0914 (N.D. Ill.); *Washington Association for Retarded Citizens, et al.* v. *Thomas*, C-79-1235V (W.D. Wash.); *Medley Macel et al.* v. *Leon Ginsberg, Commissioner of West Virginia, Department of Welfare, et al.*, 78-Civ-2099 CH (W.Va., S.D.); *New Jersey Association for Retarded Citizens, Inc., et al.* v. *Klein et al.*, 79-1632 (D.N.J.); *Barbara C.* v. *Timothy Moritz et al.*, C-2-77-887 (S.D. Ohio); *Henkin* v. *Dept. of Social Services, et al.*, 78-4088 (D.S. Dak.); *Welsh* v. *Noot*, 4-72-451 (D.Minn.) (formerly *Welsh* v. *Likens,*) 550 F.2d 1122 (8th Cir. 1977)) It should be noted that not all states joining in this brief have similar issues presently being litigated in the federal courts, *e.g.* the State of Nebraska has entered a consent decree in the case *Horacek* v. *Exon*, 72-L-299 (D. Neb).

Amici address below the fundamental issue and error of the Court of Appeals' decision: the construction of the least restrictive environment provision of the Bill of Rights, 42 U.S.C. § 6010(2), so as to impose a sweeping and mandatory duty upon states, independent of the receipt of federal funds and absent workable standards. That duty as defined by the Court of Appeals, is that the states provide special services to *all* developmentally disabled persons, (irrespective of their individual status and the degree of present state involvement in their care and habilitation). Such special services include the creation by the states of community-based alternatives to existing state-operated facilities.

Such a ruling by the Third Circuit has significant ramifications both to provision of services to the developmentally disabled and in potential financial impact on the states. Relying on powers granted pursuant to Section 5 of the Fourteenth Amendment, the Court has held that Congress may mandate an affirmative right to services from the state to one group of citizens which no other group enjoys. The creation of such an affirmative right not only constitutes a frontal assault on the fiscs of the states, *cf. NYSARC, Inc., et al.*, v. *Carey,* Civil Nos. 80-7289, 80-7295 (2nd Cir., filed June 4, 1980) and *Welsh* v. *Likens,* 550 F.2d 1122 (8th Cir. 1977), and on the powers granted to the states under the Tenth Amendment, *cf. National League of Cities* v. *Usery,* 426 U.S. 833 (1976), but creates the very distinct possibility of a plethora of potential equal protection suits by other handicapped citizens claiming the same rights granted to the developmentally disabled. For if the developmentally disabled may be "confer(red) an entitlement to such funds as may be necessary to realize the advantages of . . . freedom," *Harris* v. *McRae,* 48 U.S.L.W. 4941 (U.S. June 30, 1980), or to the maximization of their developmental potential in the setting least restrictive of their personal liberty, 42 U.S.C. § 6010(2), all other disadvantaged citizens should have such an entitlement as well.

Further, and more importantly, the obligation imposed upon the states by the Act, as construed by the Third Circuit, takes away from the states their traditional function of directing the care and treatment of the developmentally disabled and places that function with the federal government. The construction of the Act by the Third Circuit therefore raises fundamental questions of federalism which must be addressed by this Court.

SUMMARY OF ARGUMENT

It is the position of the Amici that the relief ordered by the Court of Appeals for the Third Circuit in *Halderman* v. *Pennhurst,* 612 F.2d 84 (3rd. Cir. 1979) is based on an erroneous construction of the Developmental Disabilities and Bill of Rights Act, 42 U.S.C. §§ 6000 *et seq.*, as a whole, and in particular on an interpretation of the provisions of Section 6010(2) of that Act. By reading provisions of Section 6010 to create private substantive rights for all developmentally disabled citizens and concommitant obligations on the states to provide services to such persons, regardless whether states receive or expect funds under the Act or have in any way intruded on the liberty of these individuals, the Court imposed obligations on the states regarding disabled citizens which are vague, unworkable, unrealistic and far different from the obligations the states have to their non-developmentally disabled citizens. In so doing, the Court awarded relief contrary to the plain language or legislative histories of the Act, or to the Fourteenth Amendment.

In part I of the Argument, Amici will discuss the provisions of the Act, determining that, to the extent that Congress intended to benefit developmentally disabled citizens through the 1975 and 1978 Amendments thereto, it did so by the design of a complex system of allotments of funds to the states for the purpose of filling gaps in the state service systems for those citizens. The structure of the Act and the history of those

Amendments make clear that in providing benefits to this group, Congress followed a pattern consistent with other enactments under its spending powers. Congress assisted and encouraged the states to improve services to the developmentally disabled through financial allotments to states and the provision of requirements in state plans by which programs so funded would be monitored and implemented. The Act evidences no intent, whatsoever, on the part of Congress to create substantive rights separate from funding under the Act.

Part II of the Argument assumes *arguendo* that the Bill of Rights section of the Act did create substantive rights and then examines the scope and meaning of these rights based on the statute and Constitutional law. Amici here focus on the Court's holding that the right to treatment in a setting least restrictive of a person's liberty placed an affirmative obligation on the states to create community alternatives for developmentally disabled persons, except in certain rare cases which were only vaguely described by the Court.

Amici believe that this construction of Section 6010(2) is based on a central and erroneous premise, as a matter of both statutory and Constitutional law; *i.e.*, that the right to treatment in a "least restrictive environment" is equivalent to a preference or mandate for de-institutionalization. As a matter of statutory construction, the Court's finding of a "preference for de-institutionalization" in Section 6010(2) is flawed for two reasons. First, the implication of such a preference in that Section rests on a misreading of the history of the 1975 Amendments. That history illustrates that to the extent any such preference was contained in those bills, it was inextricably tied to the funding sections which back Title III of the Act and was never equated with the "rights" which were enacted in Section 6010(2), a compromise of a different section of one of these bills. It is, therefore, inappropriate to read Title III of the Act to interpret the provisions of Title II. Second, although the

Court did read the Act this way and found such a preference in Title III, its statutory analysis was selective in that it failed to consider the 1978 Amendments to Title III which are interpretative of Section 6010(2).

While the Act does not support the relief ordered below, the Court also construed its interpretation of Section 6010(2) as being within the scope of judicially declared "rights" under the due process clause of the Fourteenth Amendment. This construction is plainly erroneous; any right to treatment under the Constitution is limited to situations in which a liberty interest is impaired. It therefore follows that the touchstone for any inquiry regarding the restrictiveness of that treatment is liberty, and whether that liberty may be freely exercised elsewhere. The Courts have not and should not measure restrictiveness of treatment against current notions of effectiveness of treatment settings. The lower Court's construction of the language in Section 6010(2) would convert a Constitutional right to freedom from unwarranted governmental intrusions on personal liberty into an affirmative right to the creation of alternative settings by the state. The creation of such a right is unsupported by, and contrary to judicial decisions, exceeds Congress' Fourteenth Amendment powers, and ignores the integrated plans and policies of the states to care for their developmentally disabled.

ARGUMENT

I.

THE BILL OF RIGHTS SECTION OF THE DEVELOPMENTALLY DISABLED ASSISTANCE AND BILL OF RIGHTS ACT CREATES NO SUBSTANTIVE RIGHTS IN FAVOR OF THE DEVELOPMENTALLY DISABLED.

The instant matter turns upon the construction of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000 *et seq.* (hereinafter the "Act"). As interpreted by the Third Circuit, the Act and particularly the Bill of Rights sections thereof creates a right to treatment and/or habilitation in favor of the developmentally disabled, and places on the

states a mandatory obligation to provide that habilitation in the least restrictive environment. The latter phrase was construed by the Court as being a "community environment" in all but a few cases. *Halderman* v. *Pennhurst,* 612 F.2d 84, 107 (3rd Cir. 1979) (hereinafter "*Pennhurst*"). Such a construction is entirely without basis in either the plain language of the Act, the regulations interpreting the Act, or in its legislative history.

A.

The DD Act: Requirements on Participating States.

The Act, like the Medicaid Assistance Program under Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.,* provides grants to states electing to participate in the program. The overall purpose of the program can be found by looking to the language of the Act: "to *assist* states to assure that persons with developmental disabilities receive the care . . . necessary to enable them to achieve their maximum potential . . ." (emphasis supplied) 42 U.S.C. § 6001(b)(1). The assistance provided under the Act comes in the form of federal grants to participating states. The grant must be expended by the state pursuant to a state plan which is approved by the Secretary of Health and Human Services. 42 U.S.C. § 6063(a). The plan must describe in detail the specific objectives to be achieved and list the programs and resources to be used to meet the objectives. 42 U.S.C. § 6063(b)(a)(A). Further, the state plan must be supported by assurances that the human rights of all persons receiving services assisted by monies provided under the Act will be protected. 42 U.S.C. § 6063(b)(5)(C).

Other requirements on the states which participate in the Act's grant program include: the establishment of a protection and advocacy system to champion the rights of persons with developmental disabilities, 42 U.S.C. § 6012; the establishment of a state planning council to serve as advocates of persons with

developmental disabilities, 42 U.S.C. § 6067; and a requirement of a habilitation plan for each person receiving services assisted under the Act, 42 U.S.C. § 6011.

The sanction contained in the Act for failure to continue to satisfy the requirements placed upon participating states is the termination or reduction of the federal grant. 42 U.S.C. § 6065. No private right of action is recognized in the Act. As can be seen from the plain language of the statute, the Act was enacted to assist the states in providing habilitative services to their developmentally disabled population, not to mandate any specific type of service.

B.

The Bill of Rights, 42 U.S.C. § 6010.

The Bill of Rights section of the Act, 42 U.S.C. § 6010, when read in conjunction with the entire Act, stands as a Congressional statement of underlying policy which serves as the foundation and explanation of the elaborate funding mechanism seen in the Act. Section 6010, when read in this context, cannot be interpreted as a mandate for the states or a statement of legally enforceable individual rights. The very language of Section 6010 negates such a construction.

In all other sections of the Act which mandate some action on the part of participating states, that action is clearly specified. See: 42 U.S.C. §§ 6010(3), 6011, 6063, and 6065. In stark contrast is the language of Section 6010 which begins: "Congress makes the following *findings* respecting the rights of persons with developmental disabilities . . ." (Emphasis supplied.) Such language cannot and does not create obligations on the part of the states. Instead it is, as is stated above, an introductory statement of underlying policy or a preamble. "Findings" are meant to serve as guidance to the courts in the interpretation of an act and are meant to justify and support the

action taken by Congress in its passage. See generally: *United States* v. *Carolene Products Co.,* 304 U.S. 144, 152 (1938); *Maryland* v. *Wirtz,* 392 U.S. 183, 189 (1968). It is generally recognized that language found in a preamble of a statute and not seen elsewhere confers no rights not otherwise enacted. *Yuzzo R.R. Co.* v. *Thomas,* 132 U.S. 174, 178 (1889).

The location of Section 6010 in the Act as passed, rather than as codified, supports the characterization of the section as a preamble. Public Law 94-103, 89 Stat. 486 (1975) contained three Titles. Title I concerned the provision of services and facilities to the developmentally disabled. Title II encompassed the rights of persons with developmental disabilities and Title II contained several miscellaneous provisions. Section 6010 was the preface of Title II followed by provisions later codified as Section 6011 (requirement of individual habilitation plans), 6012 (establishment of protection and advocacy systems), and 6009 (requirement that HEW establish evaluation system to assure *inter alia* the rights enunciated in 42 U.S.C. § 6010 were protected.) The Congressional findings in Section 6010 were designed simply to serve as the rationale for the mechanisms set forth in the remainder of Title II, which would implement those findings.

Finally, the language of the "findings" themselves indicates that Section 6010 was intended to be merely directory and not create substantive obligations on the part of the states. In Section 6010(2) and (4) the directory "should" is used as opposed to the mandatory "shall". Had Congress intended to create enforceable legal rights, it certainly could have chosen more direct, forceful language to accomplish its purpose. Indeed, it used such language in this Act; in contrast to this directory language in Section 6010 are those provisions of the Act which do in fact mandate action on the part of participating states, *i.e.,* Sections 6011(a)(b), 6012, 6063 and 6067.

In Section 6011(a) it is stated, "the Secretary *shall* require as a condition to a state's receiving an allotment . . . a habilitation plan . . . ." Mandatory language similarly appears in Section 6011(b) where it is stated, "a habilitation plan for a person with developmental disabilities *shall* meet the following requirements . . . ." Section 6012 of the Act which requires the establishment of a protection and advocacy system provides, "the Secretary *shall* require as a condition to a state receiving an allotment . . . that the state . . . will have in effect a system to protect and advocate the rights of persons with developmental disabilities . . ." Similarly, in Section 6063 which contains the requirement for submission of a state plan, the mandatory "must" is used throughout rather than the directory "should." Finally, in Section 6067 which requires the establishment of the state planning council, the mandatory "shall" is used to describe the state's obligation. It can therefore be seen that where Congress intended to place specific mandates on states participating in funding grants under the Act it did so directly with forceful, commanding language. In light of this comprehensive reading of the Act, Section 6010 stands out as merely precatory, designed to encourage, rather than mandate, a desired course of conduct.

C.

The Legislative History of the Bill of Rights Provision.

The *Pennhurst* court assumed that the Bill of Rights provisions of the Act, as added in 1975, created a "maximum duty" on the states, in contrast to the minimum expenditure requirements in Title III of the Act. 612 F.2d at 107. The legislative history of the Bill of Rights negates any such conclusion.

The Bill of Rights sections of the present Act resulted from a "compromise" joining together the 1975 House (H.R. 4005) and Senate bills (S. 462) to create the 1975 amendments to the

Act. The major focus of the "compromise" was on this Bill of Rights, for while the House bill contained no such provision whatsoever, Title II of the Senate bill contained some 330 pages of standards to assure the humane care, treatment, habilitation and protection of the mentally retarded and other persons with developmental disabilities served by residential and community facilities and agencies. See statements of Congressman Rogers, 121 Cong. Rec. 29309 (1975), Senator Williams, *Id.* at 29821.

The "compromise" of the Bill of Rights in Title II is important in two respects: first, like the House bill, and Title I of the Senate bill, the declarations in Title II were not designed to create any rights or obligations except pursuant to the receipt of grants by various facilities and agencies as defined in the Title.[2] It is therefore inconsistent with the history of the Bill of Rights to read the watered down version of Title II to create a "maximum duty" different from an "expenditure requirement."

Second, S. 462 included specific procedural criteria designed to assure that the Bill of Rights provision was fully implemented. See S. Rep. No. 94-160, 94th Congress, 1st

[2] The structure of Title II of S. 462 clearly establishes that the bill was not intended to create general obligations, but rather "to stimulate the states to develop alternative programs of care for the mentally retarded," 1975 Senate Report at 1, through appropriations to the states. Title II was divided into four parts. Part A, which contained the general provisions for residential and community facilities, set forth compliance provisions relating to the standards established for facilities and agencies pursuant to Parts B, C and D of the title. See 121 Cong. Rec. at 16477-16480. The provisions of the various criteria for evaluating individuals (Part B) and institutional (Part C) and community (Part D) facilities all must be read in connection with the compliance standards in Sections 203-206 of the title. With regard to the specific provisions of Part D relating to community facilities, the provisions of each section of that part are specifically limited to facilities and agencies receiving federal assistance under this Act. See, e.g., Sections 286(b), 287(b), 288(b), 289(b), 290(a), 291(b), 292(b), 294(b), 295(b), 296(c), 299(b), 299A-299X(b).

Session (1975) at 45-46 (hereinafter "1975 Senate Report"). The Conference Committee rejected the explicit standards implementing the Bill of Rights in the Senate version of the Act in favor of a more generalized statement of Congressional "findings." H.R. Conf. Ref. No. 94-473, 94th Congress, 1st Session (1975) at 961 (hereinafter "1975 Conference Report"). This rejection is also evidence that Congress had no intent to create an enforceable "maximum duty" on the states.

The comments of the House Conferees regarding the nature of the compromise further negate the finding of any such intent. In speaking of the compromise Congressman Rogers stated:

> With respect to the Senate's very long second title, we were able to get them to agree to a much shorter version . . . which makes a brief statement of the rights of the developmentally disabled to appropriate treatment and care. *These are modest requirements which we were able to find among the Senate's long list of standards and considered reasonable at this time.* (Emphasis supplied) 121 Cong. Rec. 29309 (1975).

The Senate Conferees discussing the compromise also recognized the shortened Bill of Rights provision to be solely a statement of Congressional policy. As Senator Javits stated in discussing the Bill of Rights:

> Mr. President, this "Bill of Rights" represents a reaffirmation of the basic human and civil rights of all citizens. It provides the *direction and framework* for improving the overall situation of this country's mentally retarded and other developmentally disabled individuals. (Emphasis supplied) 121 Cong. Rec. 29830 (1975)

See also statement of Senator Williams, 121 Cong. Rec. 29821 (1975).

It can therefore be seen that the Conference Committee report and the statements of the conferees recognized that the

Bill of Rights section of the Act, as adopted by Congress, was a statement of policy which contained "modest requirements" to give the states some "direction and framework" within which states receiving funds under the Act should operate. Reading the Bill of Rights to create a "maximum duty" does violence to this legislative history and the fact that Title II was compromised.

D.

Regulations Implementing the Act.

The regulations implementing the Act, while extensively governing the funding mechanisms in the Act, contain no regulations implementing the Bill of Rights Sections of the Act in such a way as to create an affirmative duty on the states. Instead, the regulations reinforce the stated purpose of Congress in enacting the Act. The regulations provide:

> The purpose of the Act is to *improve* and *coordinate* the provision of services to persons with developmental disabilities. . . . . (Emphasis supplied) 45 C.F.R. § 1385.1

With regard to the issue of deinstitutionalization, the regulations reiterate the goals of Congress and require the state plan to address the elimination of inappropriate placement of developmentally disabled and the improvement of care of persons who are appropriately placed in institutions. 45 C.F.R. § 1386.42. In detailing the requirements to be placed upon participating states in planning for community alternatives to institutionalization, the regulations provide:

> The state plan shall support the establishment of community programs as alternatives to institutionalization and support such programs designed to provide services for the care and habilitation of persons with developmental disabilities, and which utilize, to the maximum extent feasible, the resources and personnel in related community programs to assure full coordination with such programs

> and to assure the provision of appropriate supplemental health, educational or social services for persons with developmental disabilities. 45 C.F.R. § 1386.43.

The above provisions can hardly be said to create sweeping rights on behalf of the developmentally disabled. If anything, the regulations recognize that the Act was meant to be a funding mechanism only to encourage the stated goals. This construction is further confirmed by the fact that the only sanctions contained in the regulations for failure to comply with their terms is a withdrawal or reduction of payments. 45 C.F.R. § 1386.2, 1386.16. Indeed, while those regulations newly proposed by the Rehabilitation Services Administration (which have yet to be promulgated) do contain a section dealing with the rights of persons with developmental disabilities, 45 Fed. Reg. 31008, May 9, 1980, even those proposed regulations do nothing to create enforceable rights on the part of the developmentally disabled. Instead, the sanction for failing to fulfill the requirements of the regulation is a possible loss of funding received under the Act. Thus, the construction given to the Act by the Court of Appeals is contrary to the construction of the agency responsible for enforcing the Act. In such cases, the construction of the agency should be given great weight by the reviewing court. *Brennan* v. *General Telephone of Florida*, 488 F.2d 157 (5th Cir. 1973).

In light of the foregoing, the Act and the Bill of Rights provisions thereof can only be construed as a Congressional statement of purpose underlying a complex funding mechanism designed to assist and encourage the states to further develop community alternatives to institutionalizaton.

II.

THE PENNHURST COURT'S INTERPRETATION OF THE "LEAST RESTRICTIVE ENVIRONMENT" STANDARD OF THE DEVELOPMENTALLY DISABLED ASSISTANCE AND BILL OF RIGHTS ACT IS CONTRARY TO THE ACT, THE LEGISLATIVE HISTORY OF THE ACT AND THE UNITED STATES CONSTITUTION.

In Part I, Amici have shown that the Act in general, and the Bill of Rights sections in particular, do not create rights or affirmative duties on the part of the states independent of the grant of federal assistance. However, assuming *arguendo* that this Court should find that the Act does create enforceable rights apart from its spending provisions, it is essential to address the scope of the rights which the Third Circuit found to have been created in the Act, for, as Chief Judge Seitz noted in his dissent, the ultimate issue is not so much the issue of whether a right was created by the Act, but rather, the "contours and substance of the right." 612 F.2d at 117.

The Court of Appeals concluded that the Act creates an affirmative duty on the part of states to deinstitutionalize residents of institutions, irrespective of costs, available resources or state policy. That conclusion was based on the premise that the language in 42 U.S.C. § 6010(2) that treatment be "provided in the setting that is least restrictive of a person's personal liberty," is equivalent to a "preference for deinstitutionalization." *Id.*, 612 F.2d at 104. Finding that "preference" in the provision of Title III of the Act, and in its legislative history, the Court used those sources to build the preference into a presumption that "deinstitutionalization is the favored approach to habilitation," 612 F.2d at 115, and to conclude that all persons residing at the Pennhurst State School & Hospital should be placed in the "community" except in rare circumstances.

The Court's construction of the Act and the concomitant obligations that flowed from that construction rest on one

central and erroneous assumption: that as a matter of statutory construction and/or Constitutional law, the phrase "least restrictive environment" is equivalent to deinstitutionalization. This equation is plainly erroneous under any reasonable reading of the Act, its legislative history, or the Constitution.

A.

Neither the Legislative History of the Act in General nor of 42 U.S.C. § 6010(2) in Particular Supports the Result Reached by the Third Circuit.

In its construction of the rights created by the Act, including the right to treatment in the "least restrictive environment," the *Pennhurst* majority asserted that the Act created maximum duties, through its Bill of Rights sections, while construing other sections of the Act, namely, the state plan requirements in Title III, 42 U.S.C. §§ 6061 *et seq.* to be only minimum expenditure requirements. 612 F.2d at 107. Although the Court of Appeals recognized a basic difference between the provisions of 42 U.S.C. § 6010(2) and the state plan sections of the Act, the Court chose to selectively use the state plan or "minimum expenditure" sections of the Act to interpret the very sections it saw as creating maximum rights.

The Court's analysis of the rights created by the Act rests on a fundamental error in statutory construction. References to deinstitutionalization seen in the language and legislative history of the more limited "state plan" sections of Title III of the Act, in particular in 42 U.S.C. §§ 6063(b)(20) and (23) were used by the Court to interpret the provisions of 42 U.S.C. § 6010(2). The legislative history of the Act demonstrates that the deinstitutionalization sections were always separate from any general rights and were never used to interpret, explain, or define the portions of the bill which became Section 6010. In short, even assuming *arguendo* that Section 6010(2) was designed to create substantive rights, those rights were never equated with deinstitutionalization by the draftsmen of the Act.

An inherent inconsistency in analysis compounds this fundamental error in statutory construction. After assuming that the provisions of the state plan section of the Act had created a preference for deinstitutionalization in the Bill of Rights section, the Court ignored the fact that later amendments to the Act deleted all language that could serve as the basis for that preference. When the legislative history of, and the 1978 Amendments to, the Act are examined, it is clear that there is simply nothing in the Act or its history which supports the construction given to Section 6010(2) by the Court of Appeals.

1.

The Legislative History of the 1975 Amendments.

The Court of Appeals found a general right to treatment in the least restrictive environment in 42 U.S.C. § 6010(2). As noted in Part I C, *supra,* that section emerged from the Conference Committee report regarding the proposed 1975 Amendments to the Act, and in particular from the provisions of Title II of S. 462. A review of the provisions of Title II itself demonstrates that nothing in that Title supports the Court's construction of Section 6010(2) as creating a preference for deinstitutionalization or any affirmative obligation to create community placements.

As Amici have shown above, the rights contained in Title II of the proposed Senate bill were limited by the receipt of funds. However, more important to the instant discussion is the fact that even though the Title contained some 48 definitions in its 330 pages, it never defined the terms "least restrictive environment" or "deinstitutionalization", much less equate the two. See 121 Cong. Rec. at 16477-16514.

While it did not define the term, Title II of S. 462 did refer to the concept of "least restrictiveness." Yet, here again the legislative history cannot support the broad interpretation of the

phrase adopted by the Court. Generally speaking, the concept was used to describe a manner of treatment which would be "least restrictive" of the person's capabilities and needs, or "conducive to development." See, *e.g.*, §§ 211(e) and 299X(b)(2)(B) of Title II of S. 462 at 121 Cong. Rec. 16481 and 16512. In the Committee Reports, the term was given several different interpretations. *Cf.* 1975 Senate Rep. at 28, 31, 33, 48, and 51. But in both the Act and the Senate Reports, the requirement of least restrictiveness was never specifically equated with placement out of an institutional facility, nor is it imposed as a requirement separate and distinct from funding. Indeed, other language in Title II demonstrates that where the Senate wished to refer to community placement as opposed to the least restrictive environment, they did so in specific language. See, for example, Section 215(12), 121 Cong. Rec. at 16481, Section 223, *Id.* at 16482, and Section 268, *Id.* at 16498.

When Title II was "compromised" in the Conference, Section 6010(2) emerged in its current form. The language relating to treatment in the least restrictive setting referred not to principles of treatment or deinstitutionalization but to restrictions on liberty, a fact which at least one court has found significant. See n. 6, *infra*. The Conference Committee itself said absolutely nothing about the "right" created in Section 6010(2); it simply referred to it in passing in the Report. 1975 Conf. Rep. at 42.

As noted in Part I-A, *supra*, in all of the laws preceding the 1975 Amendments, Congress had legislated in the area of developmental disabilities by providing grants to states for planning, administration, construction and other services. The creation of federal priorities or preferences was accomplished by the control over federal funds in the form of state plan requirements. In 1975, when Congress sought to add provisions regarding deinstitutionalization to the law it was consistent with past practices; *i.e.*, it added those provisions to the funding sections of the Act.

The House version of the 1975 Amendments contained a specific earmark for deinstitutionalization by requiring each state to use a given portion of its allotment for "developing and implementing plans designed to eliminate inappropriate placements in institutions," and by including, in the state plan requirements, a plan to eliminate such placements. See 1975 Conf. Rep. at 32-33. These sections became 42 U.S.C. §§ 6062(a)(4) and 6063(b)(20) of Title III. The House bill contained no bill of rights whatsoever; rather, the obligations it imposed regarding deinstitutionalization were limited solely to funding and even then, the obligations were limited to as much deinstitutionalization "as was feasible." 42 U.S.C. § 6063(b)(20). The history of the House bill certainly cannot be read to have created a general requirement of deinstitutionalization.

The Senate bill addressed the issue of deinstitutionalization in the same manner as the House bill, *i.e.*, by the addition of specific goals to the state allotment and planning portions of the bill. See 1975 Senate Report at 16-17; 1975 Conf. Rep. at 33; and 121 Cong. Rec. at 16473-16477. Although much attention has been focused on the broad Bill of Rights section, the only specific reference to deinstitutionalization in the Senate bill was contained in Title I of that bill. As in the House version, the requirement of deinstitutionalization in the Senate bill was tied to funding granted to the states and was a limited obligation designed to create community alternatives to institutions to the "maximum extent feasible." See § 114(a)(5) of S. 462; 121 Cong. Rec. at 16475. See also H.R. Conf. Rep. at 32.

The structure of the bills which became the 1975 Amendments demonstrates that to the extent that concerns or obligations regarding deinstitutionalization were included in the 1975 Amendments, they were: (1) limited to *feasible* deinstitutionalization to be accomplished pursuant to federal funding; and (2) included in the state plan sections of the bills, which became Title III of the Act. The creation of any preference for

deinstitutionalization as expressed in these bills and was, and is, totally unrelated to the allegedly more general obligations in Section 6010(2) which were contained in the compromise that grew out of Title II of the Senate bill. The provisions of Title III cannot be read to create a broad obligation out of the compromise of Title II.

Similarly, the comments of Senators and Congressmen, with regard to the Act, must be read with reference to the bills being discussed. For example, the majority uses the comments of various Congressmen on the House bill, H.R. 4005, to interpret the provisions of 42 U.S.C. § 6010(2). See 612 F.2d at 104-105. However, at the time the cited comments were made, the House version of the bill contained absolutely no bill of rights section or any reference to the term "least restrictive environment"; the comments referred solely to an obligation to be imposed through state plans. While those comments may support a "preference for deinstitutionalization," that preference is totally unrelated to the concept of least restrictive environment ultimately seen in the Bill of Rights section.

The same problem exists with respect to the comments of various Senators cited by the Court. In nearly every case, those comments were made specifically with respect to the provisions of Title I of the Senate bill, which were later incorporated in the state plan sections of the Act rather than with respect to the Bill of Rights section which contained references to the least restrictive alternative. See, *e.g.*, comments of Senator Randolph, 121 Cong. Rec. at 16516; Senator Williams, *Id.* at 16517; Senator Cranston, *Id.* at 16520; Senator Stafford, *Id.* at 29819; and Senator Williams, *Id.* at 29821.[3]

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[3] Indeed, as was the case with the House comments cited above, the various comments of the Senators cited by the Court at 612 F.2d at 105-107 were made prior to the compromise which added Section 6010(2) to the bill and thus cannot be read to construe that section.

In summary, when the 1975 House and Senate bills which added a "preference for deinstitutionalization" are examined more carefully, it becomes clear that any preference in the state plan section of the Act cannot be used to interpret the provisions of the Bill of Rights section and certainly cannot support the equation of a general right to treatment in the least restrictive alternative with a right to deinstitutionalization.

2.

The 1978 amendments

Assuming, *arguendo*, that the Court properly interpreted references to deinstitutionalization in Section 6063 to create a preference in Section 6010(2), consistent statutory interpretation requires that the 1978 Amendments affecting that preference be taken into account. The Court of Appeals used Title III selectively, ignoring those Amendments, which destroyed any preference that might arguably have been created in 6010(2) in 1975.

In 1978 Congress acted to clarify the goals created in the Amendments of 1975, to give the states further direction in the expenditure of funds, as well as further discretion in the operation of state programs.[4] Congress accomplished these

[4] It is noteworthy that in spite of the Court's conclusion that a clear preference for deinstitutionalization had been created in 1975, Congress found no such clarity. The House committee considering the 1978 Amendments found that the states were "lacking clear legislative or administrative guidance concerning priorities." H.R. Rep. No. 95-1188, 95th Cong. 2nd Sess. (1978) at 10. If the impact of the 1975 Amendments was to create a clear preference for deinstitutionalization and to establish a mandatory obligation on the part of the states to create community services, one must wonder why the matter was so confused in 1978. Whatever the reason for that confusion, its resolution by Congress hardly supports the contention that such a preference or mandatory right was created. It is also noteworthy that the 1978 House Report and Conference Report, H.R. Conf. Rep. 95-1780 (1978) makes no mention of the Bill of Rights sections.

ends by deleting the minimum expenditure requirements in U.S.C. § 6062(2)(4), as well as the "insistence on specific deinstitutionalization plans in Section 6063," on which the Court relied to find a preference. See 42 U.S.C. § 6063 as amended by P.L. 95-602, 92 Stat. 3011. As amended the Act provided further flexibility to the states in the expenditure of funds by identifying four areas of priority services. The states would be required to spend the funds alloted under the Act in no more than two of those four areas which included: individual case management; child development services; alternative community living arrangement services, and non-vocational social developmental services. See U.S.C. § 6063(b)(4). Under the 1978 Amendments, deinstitutionalization was no longer recognized as a preference. To the extent that deinstitutionalization remains a goal, it is only one of four priorities under the Act. See 42 U.S.C. § 6001(b).

In addition to the establishment of the four priority areas of service, the 1978 Amendments provide that a state must expend not less than $100,000 or 65 percent of the amount available to the state, whichever is greater, for "service activities" in "not more than two" of the priority service areas. See U.S.C. § 6063(b)(4)(B)(iv)(I). The term "service activities" is defined for purposes of that section as including among other activities: "activities to increase the capacity of institutions and agencies to provide services in the area." 42 U.S.C. § 6063(b)(4)(B)(iv).

In light of the deletion of any specific reference to deinstitutionalization in the 1978 Amendment, it is highly questionable whether it is still possible to find any preference for deinstitutionalization in Section 6010(2) or in the Act. Moreover, by reading together the definitions of priority services and "service activities," it is clear that a state may now expend all of its funds to increase the capacity of its institutions to provide services in one of the priority areas, for example, case management. The result in *Pennhurst* cannot be sustained.

B.

The Relief Ordered By the Court of Appeals Goes Beyond Any Liberty Interest Granted Pursuant to the Fourteenth Amendment.

Since neither the legislative history of 42 U.S.C. § 6010(2) nor the Court's interpretation of that section in light of Title III of the Act supports the Court's broad reading of the obligation to provide habilitation in the least restrictive environment, it is necessary to look elsewhere to determine the "contours and substance" of that right. The Court of Appeals looked to the Constitution. Amici agree that this is the proper source of construction of any "right" which might have been created in 42 U.S.C. § 6010(2); however, the Court was plainly wrong when it concluded that:

> "Section 6010 does not go beyond what has been judicially declared to be the limits of the fourteenth amendment . . ." 612 F.2d at 98.

In contrast to its discussion of a broad constitutional right underlying the right to treatment, i.e., "a right to be free from and obtain judicial relief for unjustified intrusions on personal security," derived from *Ingraham* v. *Wright*, 430 U.S. 651 (1977), the Court of Appeals identified no such "judicially declared" right in its later discussion of the right to least restrictive environment. Instead, the Court simply referred to *Ingraham* and to various constitutional cases cited by the District Court to conclude that it had "no doubt about Congressional power to impose the least restrictive alternative requirement upon the states for patients who do not require institutionalization for adequate habilitation." 612 F.2d at 107; *see also, Id.* at 104, n. 27. Using these precedents, the Court of Appeals ordered relief which: (1) created a right to treatment or habilitation in the least restrictive alternative for persons who have never had any liberty interest impaired by the State; (2) interpreted that right in reference to the most effective or most appropriate placement, rather than with reference to restrictions

on liberty; and (3) created an affirmative duty on the part of the states to create alternatives for the exercise of freedom.

Such relief cannot be derived from *Ingraham* or from any of the decisions cited by the Court. The relief ordered is plainly erroneous in each of its aspects. First, the right to treatment/habilitation and the related least restrictive alternative principle arise only when a liberty interest is implicated. Second, since the concept of least restrictiveness is related to a liberty interest only, it does not create a right to the most effective treatment or to placement in the most effective setting. Third, nothing in *Ingraham* or any of the other cases cited by the Court converts the right to be free from unjustified intrusions on liberty into an affirmative right to the creation of alternatives to permit the exercise of liberty. The relief granted by the Court of Appeals would convert the principle of "least restrictiveness" which, to the extent it has been judicially recognized, is designed to limit governmental intrusions on a person's liberty, into an affirmative obligation on the part of government to create or to provide the means for realization or individual freedom.

A proper understanding of the Court's erroneous construction of the principle of least restrictiveness must begin with the right to treatment to which that principle has been connected. It is well established that the states have no constitutional obligation to provide services to its citizens absent Fourteenth Amendment considerations. *San Antonio School District* v. *Rodriquez,* 411 U.S. 35 (1973); *Lindsley* v. *Normet,* 405 U.S. 56 (1972); *Dandridge* v. *Williams,* 397 U.S. 471 (1970); *NY-SARC, Inc. and Parisi, et al.* v. *Carey,* Civil Nos. 80-7289, 80-7295 (2nd Cir., filed June 4, 1980); *Rone* v. *Fireman,* 473 F.Supp. 92, 118 (N.D. Ohio 1979); *New York State Association for Retarded Citizens* v. *Rockefeller,* 357 F.Supp. 752, 761 (E.D.N.Y. 1973). To the extent that any constitutional right to habilitation or treatment for mentally retarded or mentally ill individuals has been found, it has been limited to persons involuntarily committed by the state to institutions, *see, e.g.*

Wyatt v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *Rouse* v. *Cameron*, 373 F.2d 451 (D.C. Cir. 1966); *see also* cases cited at 612 F.2d 115, n. 38. It is uncontroverted as a matter of constitutional law that:

> The right of any individual to treatment exists only by reason of, and is wholly dependent on, derived from and concomitant with a deprivation by the state of the individual's Fourteenth Amendment liberty right for the purpose of treatment. *Rone* v. *Fireman, supra*, 473 F.Supp. at 119. See also *Harper* v. *Cserr*, 544 F.2d 1121, 1122-1123 (1st Cir. 1976).

Yet in spite of this judicial authority to the contrary, the Third Circuit construed the Act in a manner which created a right to habilitation in the least restrictive environment for all developmentally disabled persons, regardless of whether any liberty interest had been impaired by the states.

In addition to its failure to recognize that any right to habilitation/treatment is derived from a deprivation of liberty, the Court of Appeals also ignored the limitations on that right imposed by this Court. The right to treatment arises only where the liberty intruded upon can be freely exercised absent such an intrusion. *O'Connor* v. *Donaldson*, 422 U.S. 563 (1975). Donaldson was involuntarily confined in a mental institution even though he was dangerous neither to himself or others and could survive in freedom with assistance. The Fifth Circuit had concluded that since the only basis for Donaldson's confinement was treatment, the state had a constitutional duty to provide him with adequate treatment. This Court, however, did not go that far, but held only that "a State cannot constitutionally confine without more a nondangerous individual *who is capable of surviving safely in freedom* by himself or with the help of willing and responsible family members or friends." (Emphasis added.) *Donaldson, supra*, 422 U.S. at 476.

Given the scope of the judicially declared right to treatment as enunciated in the above-cited cases and by this Court in *Donaldson*, the only proper construction of the principle of

least restrictiveness in treatment or habilitation is one which measures the level of restrictiveness in relation to the individual's ability to independently exercise liberty in one environment as opposed to another. The concept is not a measure of the effectiveness or appropriateness of one environment over another.[5] Indeed, § 6010(2) itself refers to the "setting that is least restrictive of the person's personal liberty," 42 U.S.C. § 6010(2) and not to a "most appropriate," or "community" setting.[6]

Those Courts which have considered the issue have supported this construction and have rejected the Third Circuit's interpretation of the principle of least restrictiveness as a presumption of preference for deinstitutionalization or as a

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[5] This, of course, is nearly identical to the argument adopted by the dissent in *Pennhurst*. Indeed, it was because of the inability of the retarded to live independently in society that Chief Judge Seitz felt that the principle of least restrictiveness should not be applied in civil commitment cases, 612 F.2d at 127-128. Amici believe that Chief Judge Seitz' analysis of the constitutional arguments is correct and completely undercuts the majority's assertion of any broad right in § 6010(2).

[6] It is not coincidental that the language of § 6019(2) reflects the language in *Donaldson*, which clearly enunciated that the standard for determining whether an individual was entitled to treatment was whether the individual could exercise personal liberty outside an institution. Indeed, in *KARC* v. *Conn*, *infra*, the Court found it to be of "some significance that the [Act] was passed in 1975 after the decision of the Supreme Court in *O'Connor* v. *Donaldson*." In June of 1975, when the Act was originally introduced, Senator Javits referenced the fact that *O'Connor* v. *Donaldson* was before this Court. 121 Cong. Rec. at 16519. *Donaldson* was decided on June 26, 1975. At that time, Title II of the Senate bill contained references to the least restrictive environment which did not refer to liberty. However, when Title II was compromised in September of 1975, the compromised version of the section reflected the language of this Court's decision in *Donaldson*. It is therefore highly appropriate that § 6010(2) be construed in a manner consistent with *Donaldson*.

right to the most effective form of treatment.[7] *See, e.g., Gary W.* v. *Louisiana,* 437 F.Supp. 1209, 1217-19 (E.D.La. 1976); *Wyatt* v. *Aderholt,* 503 F.2d 1305 (5th Cir. 1974); *Welsch* v. *Likens,* 550 F.2d 1122 (8th Cir. 1977). Indeed, apart from *Pennhurst,* the courts have squarely rejected the claim that the state cannot constitutionally provide services for the mentally retarded in a state institution, or that deinstitutionalization is the favored form of habilitation. *Wyatt* v. *Ireland,* Civ. Act. No. 3195-N (N.D. Ala. filed Oct. 25, 1979) *Id.; Kentucky Ass'n. of Retarded Citizens* v. *Conn.,* Civil No. C 780157 L(A), (W.D. Ky. filed March 21, 1980).

The case law firmly supports Amici's contention that the Constitution does not establish the right to habilitation in the most appropriate setting, nor does it create a right to the best treatment available. In *Wyatt* v. *Ireland, supra,* Judge Johnson stated that the "minimum constitutional standards for adequate habilitation" did not "define habilitation as deinstitutionalization in all cases." *Id.* at 13.

In his opinion,

> [t]here is debate within the profession concerning the beneficial effects of community placement for the severely and profoundly retarded. The Court will not choose sides

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[7] It is quite possible that this Court has rejected the application of the less drastic means analysis to the conditions of civil commitment. In *State* v. *Sanchez,* 396 U.S. 276, (1970) the Court dismissed an appeal from a case which has rejected the least restrictive alternative test for "want of a substantial federal question."

> in this debate. Nor should it. . . . Determining the ideal mode of treatment, or ordering state institutions to implement the best system is beyond the province of the Court. [Footnote omitted] Slip Op. at 7.

Judge Johnson's reluctance to raise professional opinions, preferences or presumptions to the level of constitutional principles is well founded.[8] As the Court explained in *Gary W.* v. *Louisiana, supra,* 437 F.Supp. at 1218-19, in the context of an action challenging the institutionalization of mentally retarded and other children from Louisiana:

> Many of the plaintiff's expert witnesses presented what I considered sound expositions of what is presently known concerning the most desirable ways to treat children. But, just as "The Fourteenth Amendment does not enact Mr. Herbert Spender's Social Statics," *Lochner* v. *N.Y.,* 1905, 198 U.S. 45, 25 S.Ct. 539, 49 L.Ed. 937 (Holmes, J., dissenting) it does not codify current theories concerning child development or the treatment of the mentally retarded.
>
> In developing the substantive requirements implicit in the constitutional mandate of due process, courts must be careful not to impose inexorable bonds that incorporate judicial sentiments, however noble, or contemporary theories, whether social, economic, medical or psychological. Even though the constitution's precepts are evolutionary, it is after all a constitution, and not a textbook that can be revised periodically.

Indeed, although the Court of Appeals cited the decision in *Gary W.* as supporting the right to "the least restrictive setting consistent with individual habilitative needs," Court found that the "term 'least restrictive setting' is more a slogan than a constitutional imperative." *Id.* at 1209.

More recently, the Federal District Court for the Northern District of Ohio clarified the difference between a right to

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[8] It is noteworthy that the author of the decision referred to in the comment of Senator Javits relied on by the Court, see 612 F.2d at n. 17, has adopted a contrary view of the scope of the right, said to have been created in the Act, pursuant to the Fourteenth Amendment.

habilitation in the least restrictive setting and a right to habilitation in the setting which will produce the most effective results:

> As the right to treatment develops from the deprivation of liberty for that purpose, the touchstone of the Court's inquiry must be liberty. The concern is not whether the treatment is restrictive in terms of its effectiveness, but whether the method of treatment is overly restrictive of liberty . . . Due process clearly does not incorporate and require the provision of the particular mode of treatment currently preferred by most mental health professionals. As long as treatment within the hospital environment does not by comparison unduly burden the individual's liberty interest, the Court cannot find that the Constitution requires the provision of treatment in alternate settings. *Rone* v. *Fireman, supra,* 473 F. Supp. at 125.

In sum, the "scope and contour" of the constitutional right to habilitation in the least restrictive setting as interpreted by the courts does not encompass the right to treatment in a "normalized" setting or create any preference for deinstitutionalization. The first right is concerned with liberty, the latter with effectiveness of habilitation or treatment. Thus, the Court of Appeals was in error when it ruled that the term "least restrictive environment" should be equated with a preference for deinstitutionalization or the most appropriate treatment under the Fourteenth Amendment.[9]

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[9] Nothing in the cases cited in footnotes 27 and 38 of the Court's decision (except perhaps for the consent decrees) supports a contrary interpretation of the principle of least restrictiveness from that adopted by Amici. Indeed the principle in those cases demonstrates that it was precisely in the context of a comparison between the independent exercise of personal freedom and state intrusions on that freedom that the principle was devised. For example, *Lessard* v. *Schmidt*, *Suzuki* v. *Quisenberry*, *Lynch* v. *Baxley*, and *Eubanks* v. *Clarke*, cited by the Court, applied the principle to determine whether initial commitment to an institution or transfers between institutions

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Finally, the Circuit Court's application of the least restrictive environment principle in § 6010(2) to impose an affirmative obligation to create community settings is without support in the case law. See n. 9, *supra*. This construction of the statute would convert a principle which limits state intrusions on liberty into a mandate on the part of state governments to provide services and find alternatives permitting the exercise of that freedom. As the above cited cases demonstrate, the Constitution is not so broad. It confers minimum rights and does not afford individuals any rights to services absent a deprivation of liberty much less a right to ideal services. *See, e.g., Wyatt* v. *Stickney*, 344 F.Supp. 387, 391-392 (M.D. Ala. 1972), *aff'd. in part, remanded in part, and decision reversed in part, Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir.1974); *Wyatt* v. *Ireland, supra; Gary W.* v. *Louisiana, supra;* and *NYSARC and Parisi* v. *Carey, supra.* If the Constitution imposes no affirmative obligation to provide services absent a deprivation of liberty, it cannot read to require the states to create alternatives by which liberty may be exercised if an individual cannot freely do so. Indeed, this Court's recent decision in *Harris* v. *McRae*, 48 U.S.L.W. 4941 (U.S. June 30, 1980), upholding the constitutionality of the federal appropriation acts limiting funding

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were available; (2) what alternatives were investigated; and (3) why the investigated alternatives were not appropriate. *Lessard* v. *Schmidt*, 349 F. Supp. at 1096, the principle of least restrictiveness was applied to limit the states power to commit, not to impose an obligation to create alternatives to the commitment. *Wyatt* v. *Stickney* and *Welsch* v. *Likens* applied the principle to determine the least restrictive treatment consistent with individual confinement *within the facility in question*, not to require the creation of alternative placements. These decisions, therefore, demonstrate that the principle of least restrictiveness as applied by the lower courts concerns the infringement of personal liberty which might have been freely exercised absent a state intrusion. It is therefore erroneous to interpret those cases as creating a preference for one form of treatment or an affirmative obligation on the states' parts to provide services.

for abortions under the Social Security Act rejected any such reading of the Due Process Clause of the Constitution.

As the discussion of the Due Process Clause in *McRae* makes clear, a constitutional limitation on governmental infringements of protected rights does not give rise to any concomitant affirmative right to services under the Constitution.

> [A]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation . . .
>
> Although the liberty protected by the Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom. To hold otherwise would mark a drastic change in our understanding of the Constitution. . . . To translate the limitation on governmental power implicit in the Due Process Clause into an affirmative funding obligation would require Congress to subsidize the medically necessary abortion of an indigent woman even if Congress had not enacted a Medicaid program to subsidize other medically necessary services. Nothing in the Due Process Clause supports such an extraordinary result. Whether freedom of choice that is constitutionally protected warrants federal subsidization is a question for Congress to answer, not a matter of constitutional entitlement. 48 U.S.L.W. at 4946-4947.

As was the case with the welfare recipients in *McRae,* the obstacle to the exercise of freedom by the developmentally disabled (*i.e.,* their handicap) is not an obstacle of state creation. The *McRae* decision establishes that while a retarded person may have a right against unwarranted government interference with his or her freedom of choice or personal freedom, that right does not confer a right to such financial support as might entitle that individual to realize the advantages of freedom in an alternative setting. Simply put, any obligation of the state under the Due Process Clause not to

infringe on one's liberty in an institutional setting does not convert the Due Process Clause into an affirmative action clause requiring the state to fund alternative facilities.

Since the relief ordered in *Pennhurst* finds no support in "judicially declared constitutional rights" the Court's stated basis for imposing the least restrictive alternative requirement on the states is clearly erroneous and must be reversed.

In light of the statutory language of the Act and of the discussion of the decisions of this Court in *Donaldson* and *McRae,* the proper meaning of Section 6010(2) can only be that expressed by Chief Judge Seitz in his dissent:

> Drawing from *Jackson, Donaldson,* and *Bell,* I would hold that where the state confines [footnote omitted] a person against his or her will because of an inability of that person "to avoid the hazards of freedom," the conditions of that confinement must bear a reasonable relationship to the purpose of the confinement. I do not believe that a state can be constitutionally required to care for that person in a manner "least restrictive" of that person's freedom. Nevertheless, the availability of less drastic alternatives is one factor for a court to consider in determining the overall reasonableness of the challenged restraint. *See, e.g., Bell* v. *Wolfish,* [99 S.Ct. 1861, 1885 n. 40 (1979)]. 612 F.2d at 129.

Assuming therefore, that a right was created by Congress in the Act, a proper construction of the Constitution compels the conclusion that this right was limited to the right: a) to be released from institutional care when the individual can reside freely or with the willing help of family and friends; or b) to the least drastic means of confinement for individuals within an institution. Freedom from restraint on personal liberty requires nothing more. See also *K.A.R.C.* v. *Conn, supra.*

C.

The Construction of 42 U.S.C. § 6010(2) by the Court Exceeds Congress' Power to Legislate Pursuant to Section 5 of the Fourteenth Amendment.

On two occasions in the past fifteen years, this Court has confronted the scope of Congressional enforcement power under Section 5 of the Fourteenth Amendment. See *Oregon* v. *Mitchell*, 400 U.S. 112 (1970) and *Katzenbach* v. *Morgan*, 384 U.S. 641 (1966). These two cases have engendered extensive debate among the commentators[10] as well as a division among the members of this Court on the question whether Congress may, in the enforcement of the Amendment through Section 5, define the substantive scope of the Amendment.[11]

Amici submit that it is not necessary to enter into that debate here for two reasons. First, under the standard adopted by the Court of Appeals itself, the decision below must be remanded or reversed. Second, under any interpretation of Section 5, the Court's construction goes beyond the Congressional power of enforcement.

The Third Circuit recognized that serious questions would arise if the Court's construction of the Act as a "predicate for private substantive rights," rested solely on the spending power of Congress. 612 F.2d at 98. The issue was not raised the Court found because: (1) the Supreme Court had recognized

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[10] See, *e.g.*, Sager, *Fair Measure: The Legal Status of Underenforced Constitutional Norms*, 91 HARV. L. REV. 1212 (1978); Cohen, *Congressional Power to Interpret Due Process and Equal Protection*, 27 STAN. L. REV. 603 (1975); Bickel, *The Voting Rights Cases*, 1966 Sup. Ct. Rev. at 79; see also Note, *Applying the Equal Pay Act to State and Local Governments: The Effect of National League of Cities* v. *Usery*, 125 U. PA. L. REV. 665 (1977).

[11] Cf. The decisions in *Oregon* v. *Mitchell* evidence the extent of this disagreement. *Cf.* decisions of Harlan, J., 400 U.S. 152, 204-209, Black, J., *Id.*, 119, 126-131 and Stewart, J., Id., 281, 292-296 with the Opinion of Justice Brennan, *Id.*, 289, 278-281 and Douglas, *Id.*, 135, 141-144.

an underlying constitutional right to be enforced by Congress; and (2) Section 6010(2) as construed did not go beyond those judicially declared rights. The Court of Appeals therefore accepted a limitation on Congressional power similar to that advocated by Justice Harlan in *Morgan*, see Harlan, J., dissenting, 384 U.S. 641 at 843, and Professor Bickel, *supra*, n. 10 at 97-98. In short, the Court recognized that the Courts, not Congress, determine the scope and contour of substantive rights under Section 5 of the Fourteenth Amendment and that Congress cannot act to enforce rights not recognized by the judiciary.

Here, the Court's own standard provides an independent basis for reversal since, as Amici have shown in Part II-B, *infra*, not only does the Court's interpretation of Section 6010(2) exceed the judicially declared limits of the "right" it saw Congress as creating, but that interpretation is directly contrary to the decisions of this Court in *Donaldson* and *McRae*. Congress therefore, by the Court's own standard, had no authority to enact the right the Court found in Section 6010(2).

Assuming that this Court should apply a different standard regarding Congress' power under Section 5, it must still be asserted the Third Circuit's interpretation of 6010(2) cannot be sustained as a valid exercise of that Section.[12] No court,

[12] In spite of the Court's willingness to find that Congress intended §§ 6000 *et seq.* to "enforce the recognized constitutional rights" 612 F.2d at n. 17, Congress intended no such result. First, it is extremely doubtful that Congress would have gone to the trouble to set up the elaborate system of funding incentives contained in the Act if it had simply intended to obligate the states to perform mandatory duties irrespective of the receipt of funding under the Act. If this was the intent of Congress, it was accomplished in an extremely convoluted manner. Second, the amendments of 1975 and 1978 to the Act both took effect only with respect to particular appropriations under the Act. P.L. 94-103, § 303; P.L. 95-602, § 515. There is no

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particularly this one, has concluded that the Congressional enforcement power under Section 5 is unlimited. See *Oregon* v. *Mitchell, supra,* at 128. (Opinion of Black, J.) Although it is recognized that the states surrendered a certain portion of their autonomy in the ratification of the Fourteenth Amendment, *Hutto* v. *Finney,* 437 U.S. 678 (1978), *Fitzpatrick* v. *Bitzer,* 427 U.S. 445, (1976), the power granted to the national government thereunder may not "repeal other sections of the Constitution" or "strip the states of their power to govern themselves (and) convert (the) national government of enumerated powers into a central government of unrestrained authority." *Oregon* v. *Mitchell, supra,* at 128. Here the Third Circuit's decision implicates both limitations, for the relief ordered "traverses a power of self-determination inherent in the states." *Corpus* v. *Estelle,* 605 F.2d 175 (5th Cir. 1979): *cert. denied sub nom Estelle* v. *Corpus,* ____ U.S. ____ (1980).

The Court of Appeals recognized the central problem of the right it assumed Congress to have created when it referred to the statute as a "predicate for private substantive rights." 612 F.2d at 98. For unlike other enactments, such as that in *Morgan,* which were designed to "rectify inequalities put into effect by the states," see Bickel, *supra,* n. 10 at 97, the Act as

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indication that the Act ever was to become effective with respect to activities not funded by these appropriations. Had 42 U.S.C. § 6010 been enacted under the Fourteenth Amendment, a separate and additional statement of effectiveness would have been required. Third, the 1978 Amendments to the Act "clarified" 42 U.S.C. § 6010 by providing that "[t]he rights of persons with developmental disabilities described in findings made in this section are in addition to any *constitutional* or other rights otherwise afforded to all persons." (Emphasis added.) P.L. 95-602, see 1978 House Rep. at 19 (1978). This is an absolutely clear indication that Congress was not attempting to enforce existing rights applicable to all persons under the Fourteenth Amendment, but rather was making findings regarding the human rights of developmentally disabled persons in particular.

construed by the Third Circuit creates affirmative rights for one segment of a state's population without any finding of invidious discrimination.[13] In this respect the *Pennhurst* decision breaks new ground, for if Congress can act to create affirmative rights in the absence of any deprivation of liberty, or if it may act pursuant to Section 5 without any findings of invidious discrimination, then there is nothing left of state autonomy. Indeed if the Court of Appeal's construction of the creation of private substantive rights is upheld, Congress might carve out any area in which the states have traditionally acted and force the states to fund services for its citizens in that area, quite apart from any state action. Such a result would clearly violate the Tenth Amendment. See *National League of Cities* v. *Usery, supra.* Given that this Court has recognized that the provision of services to the mentally ill or mentally retarded has traditionally been reserved to the states, the result becomes even more untenable. See *Addington* v. *Texas,* 441 U.S. 418 (1979) and *Parham* v. *J.R.,* 99 S. Ct. 2493 (1979). Such a result is contrary to recognition that the states are to be given substantial discretion and flexibility in the resolution of such problems. See *Bell* v. *Wolfish,* 441 U.S. 520 (1979); *Maher* v. *Roe,* 432 U.S. 464 (1977). Furthermore, an interpretation of Section 5 which permits Congress to create affirmative rights apart from any state action and to force the states to fund those rights would violate the provisions of Art. IV, § 4 of the Constitution which guarantees "to every state a Republican Form of Government."

Lastly, there is a further reason why the court's construction of Section 6010(2) should not be upheld. The court construed section 6010(2) in a manner which, rather than resolving a matter of equal protection, *creates* serious constitutional problems for the states. Other citizens may now come forward to claim rights equal to those granted to the

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[13] Indeed, the Third Circuit has held that mental retardation is not a suspect class subject to such discrimination. See *Doe v. Colantti,* 592 F.2d 704 (3rd Cir. 1979) relying on this Court's decision in *Massachusetts Board of Retirement v. Murgia,* 427 U.S. 307 (1976) (per curiam).

developmentally disabled, namely, the right to the maximization of their potential in the most effective setting. It defies reason to believe that Congress intended such a chaotic result.

III.

CONCLUSION

The Developmentally Disabled Assistance and Bill of Rights Act was well received by the states when enacted. The assistance provided by the Act in further planning for eventual deinstitutionalization was welcomed by all state providers. The funding received by the states participating in the program, although limited, was and is an impetus to the process of developing community alternatives. To turn this valued program of assistance into a mandate requiring immediate creation of community living arrangements and the closure of institutions defies not only the stated purpose of the Act, but also reality.

A close look at the totality of the Federal Assistance Program to the states in caring for the developmentally disabled quickly points out the errors of the Third Circuit's construction of the Act. Congress under Title XIX, 42 U.S.C. § 1396 *et seq.* provides the states massive reimbursement for care provided in residential facilities for the developmentally disabled. In order to receive this Title XIX reimbursement, the states must demonstrate compliance with Medicaid regulations as promulgated by the Department of Health and Human Services (HHS). Those regulations strictly govern all aspects of services provided the developmentally disabled in state operated institutions. Once compliance is demonstrated, or at least a plan of compliance is proposed by the state and is accepted by HHS, federal reimbursement to aid in the running of the institutions is forthcoming.

If Congress by the Act was stating a clear preference for deinstitutionalization, surely federal Medicaid funding would have been terminated or drastically reduced. Such is not the case however, and Medicaid continues to be a major source of funding for state operated facilities.

The fiscal implications of the Third Circuit's decision on the states are of great concern to Amici. It must be pointed out that the State of Illinois, Department of Mental Health and Developmental Disabilities will spend a total of $255.4 million dollars in fiscal year 1981 for the care of its developmentally disabled, of which 72.2 million dollars will be spent to fund grants to community based programs. The community based programs have received an increase in funding of 10 million dollars over fiscal year 1980. Illinois received a total allotment of 1.8 million dollars pursuant to the Developmentally Disabled Assistance and Bill of Rights Act in fiscal year 1980.

Community based programs in the State of New Hampshire similarly received a threefold increase in funding in 1980-1981. The State of New Hampshire will spend approximately 28.7 million dollars to care for its disabled population. Only $250,000 will be received by New Hampshire under the Act in fiscal year 1981. It can be seen therefore that the assistance granted to the states under the Act pales in comparison to the massive investment the states have made on their own to begin the process of deinstitutionalization.

The process of deinstitutionalization cannot be accomplished as quickly and easily as the Third Circuit assumes. Deinstitutionalization is an individualized process that is extremely complex requiring the coordination of many fields of expertise and finite resources. Congress recognized the complexity of this task in requiring the states to implement plans toward the goal of deinstitutionalization, and providing limited financial assistance in developing those plans.

The Third Circuit's construction of the Act requires the states to do the impossible—immediately deinstitutionalize without the adequate funding, time or clinical resources necessary. Moreover, if that construction is allowed to stand continuous judicial review of individual placements will be necessary.

Such results were not intended by Congress and cannot be condoned by this Court.

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On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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~~MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND~~ BRIEF FOR THE INTERNATIONAL LEAGUE OF SOCIETIES FOR THE MENTALLY HANDICAPPED AND THE ASSOCIATION FOR THE SEVERELY HANDICAPPED, AS *AMICI CURIAE*

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Welsch v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974) 8
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Hearings on S. 427 and S. 457 Before the Subcommittee on the Handicapped of the Senate Committee on Labor and Public Welfare, 93d Cong. 1st Sess. (1973) 17
S. REP. No. 160, 94th Cong., 1st Sess. (1973) ..... *passim*

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OTHER AUTHORITIES:

Butterfield, *Some Basic Changes in Residential Facilities*, in PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, CHANGING PATTERNS IN RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED (rev'd ed., Kugel & Shearer, eds., 1976).. 15

COMPTROLLER GENERAL OF THE UNITED STATES, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY (Report to the Congress, 1977) 24

Glenn, *The Least Restrictive Alternative in Residential Care and the Principal of Normalization*, in PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, THE MENTALLY RETARDED CITIZEN AND THE LAW (M. Kindred, *et al.* ed. 1976) 18

Herr, *Civil Rights, Uncivil Asylums, and the Retarded*, 42 U. CIN. L. REV. 679 (1974) 18

KING, RAYNES & TIZARD, PATTERNS OF RESIDENTIAL CARE: SOCIOLOGICAL STUDIES IN INSTITUTIONS FOR HANDICAPPED CHILDREN (1971) 16

Kushlick, *Wessex, England* in PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, CHANGING PATTERNS IN RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED (rev'd ed., Kugel & Shearer, eds., 1976) 16

McCormack, Balla & Zigler, *Cross-Institutional, Cross-Cultural Study*, 80 AM. J. OF MENTAL DEFICIENCY (1975) 16

Note, *Implementation Problems in Institutional Reform Litigation*, 91 HARV. L. REV. 428 (1977).. 27

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* FOR THE INTERNATIONAL LEAGUE OF SOCIETIES FOR THE MENTALLY HANDICAPPED AND THE ASSOCIATION FOR THE SEVERELY HANDICAPPED

The International League of Societies for the Mentally Handicapped and the Association for the Severely Handicapped move for leave to file the attached brief *amici curiae*.[1]

1. The International League of Societies for the Mentally Handicapped ("International League") is composed of 86 organizations in 65 countries on 5 continents dedicated to advancing the rights and interests of mentally handicapped people. The individual members of these organizations are parents, educators, therapists, doctors and other professionals in the field of mental retardation. Founded in 1960, the International League has consultative status with UNESCO, the Council of Europe, and other international agencies. Among its other activities, the International League provides experts who offer technical assistance in developing services for mentally handicapped individuals, develops and disseminates educational literature concerning the rights and needs of the mentally retarded, and helps promote the provision of services necessary to enable mentally handicapped persons to participate fully in society to their maximum potential.

2. The Association for the Severely Handicapped ("Association") (formerly the American Association for the Education of the Severely/Profoundly Handicapped) was founded in 1974 to develop, advocate, and implement

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[1] All petitioners and respondents have consented orally to the filing of this brief on the merits but written permission has not yet been received. The suburban county petitioners requested that it be indicated that to the extent this brief is considered a brief in support of the conditonal cross-petition for certiorari of PARC respondents, they do not consent to its filing. Application to the United States of America, intervenor, for consent to file is pending.

the provision of educational and habilitative services for severely and profoundly handicapped individuals. The Association now has more than five thousand members who include parents, educators, therapists, doctors, and other professionals. One of the association's stated objectives is the "rapid termination of living environments and educational/vocational/recreation services that segregate, regiment and isolate persons from the individualized attention and sustained normalized community interactions necessary for maximal growth, development, and the enjoyment of life."

3. *Amici* seek leave to file the attached brief because this case raises crucial issues concerning the rights of all handicapped persons to appropriate treatment, services, and habilitation in the community. In particular, *amici* join respondents and the courts below in seeking to honor Congress's pledge that the "treatment, services and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty." 42 U.S.C. § 6010(2).

4. The United Nations and other international agencies have recognized these same fundamental rights. In 1971, the U.N. Declaration on the Rights of Mentally Retarded Persons was adopted. This Declaration was inspired by—and largely follows—the International League's own Declaration of General and Special Rights of the Mentally Retarded, adopted at its 1968 World Congress in Jerusalem. The U.N. Declaration states that "the mentally retarded person has, to the maximum degree of feasibility, the same rights as other human beings." These rights include, according to the U.N. Declaration, the right to "such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential," to live "in surroundings and other circumstances as close as possible to those

of normal life," including living "with this own family or with foster parents" and participating in "different forms of community life" whenever possible. U.N. Declaration on the Rights of Mentally Retarded Persons (December 20, 1971), Articles 1, 2 & 4. The 1975 U.N. Declaration on the Rights of Disabled Persons reaffirms these rights, by providing that all disabled persons, including the mentally retarded, have the right to training, counselling, and other services "which will enable them to develop their capacities and skills to the maximum and will hasten the process of their social integration or reintegration." U.N. Declaration on the Rights of Disabled Persons (December 9, 1975), Article 6.

5. These national and international guarantees and declarations are based on overwhelming professional findings that all handicapped people, including those classified as severely and profoundly retarded, can learn, communicate with others, and enjoy the richness of normal community life. The experts have learned that developing and maintaining the abilities of retarded people requires individualized services and relationships. These are attainable only in integrated, small-scale, community-based environments, and not in institutional settings.

6. The experience of *amici* in research, training, and other activities to promote the rights and interests of retarded individuals provides them with a perspective which differs from that of the parties and other *amici* in this case. From this perspective, *amici*'s brief explains the fundamental errors in the brief of *amici* Congress of Advocates for the Retarded, Inc., *et al.*, and shows that deinstitutionalization is mandated by the record in this case. Unlike Congress of Advocates for the Retarded, Inc., present *amici* rely only on the professional opinions in the legislative and judicial record properly before this Court. This body of expertise supports the trial court's decision to deinstitutionalize all of the residents of the Pennhurst State School and Hospital.

CONCLUSION

Because *amici* have a substantial interest in this case, and because their brief provides an important perspective on the issues before this Court different than that of the parties, this motion for leave to file a brief as *amici curiae* should be granted.

Respectfully submitted,

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BRIEF FOR THE INTERNATIONAL LEAGUE OF SOCIETIES FOR THE MENTALLY HANDICAPPED AND THE ASSOCIATION FOR THE SEVERELY HANDICAPPED, AS *AMICI CURIAE*

INTEREST OF THE AMICI

As set out in detail in the motion for leave to file this brief, *amici* are national and international organizations of professionals and parents interested in securing for retarded individuals quality services necessary for them to grow to their maximum potential. *Amici* believe that the record before the trial court establishes that the Pennhurst State School and Hospital (hereinafter "Pennhurst")—and, by inference other large, isolated institutions of its type—must be abandoned in favor of community-based habilitation. Moreover, *amici* believe that this result is consistent with national policy established by Congress in the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. 6000-6081. *Amici*, therefore, support respondents herein and urge this Court to affirm the decision of the court of appeals except insofar as that decision fails to mandate the deinstitutionalization of all Pennhurst residents.

SUMMARY OF ARGUMENT

The issue addressed in this brief is whether deinstitutionalization of all Pennhurst residents and the provision of appropriate community-based habilitation services to them is justified by the trial court record and compelled by the Developmentally Disabled and Bill of Rights Act, 42 U.S.C. § 6000-6081 (hereinafter "Bill of Rights Act").

On the basis of the testimony of the experts, the courts below and Congress correctly embraced the basic scientific truth that in an appropriate environment all retarded people—even the severely and profoundly retarded—can develop and grow. Contrary to the contention of *amici* Congress of Advocates for the Retarded, Inc., *et al.*, neither the courts below in deciding the merits of the

case nor Congress in enacting the Bill of Rights Act misunderstood the nature of mental retardation.

In addition, the record in this case overwhelmingly justifies the district court's decision to transfer all Pennhurst residents into the community, because Pennhurst, no matter how modified, can never provide the services and environment necessary for habilitation. The court's decision that Pennhurst is a hopeless anachronism mirrors our national policy, as embodied in the Bill of Rights Act, that large-scale institutions like Pennhurst must be abandoned in favor of community-based habilitation.

The expert testimony presented at trial—by many of the same professionals consulted by Congress on the Bill of Rights Act—establishes that community-based services can successfully be provided all mentally retarded people. The district court order is carefully designed to achieve just what Congress mandated—the provision of services, treatment and habilitation in the least restrictive environment.

ARGUMENT

This case is about an abomination—the Pennhurst State School and Hospital. The district court record paints a gruesome picture of life within Pennhurst. Although the mentally retarded residents of Pennhurst pose no threat to our society, they are housed in crowded, unsanitary and understaffed wards, they are physically abused, their medical and educational needs are grossly neglected, and they are routinely sedated or placed in physical restraints. The residents of Pennhurst are segregated from the rest of humankind and denied the stimulus and nurture of the normal community—they simply are stored in a depersonalized, large-scale institution until they quietly die.

On the basis of an extensive record, the district court found that the conditions at Pennhurst are intolerable. The district court also found that it is inherently impos-

sible, in a large-scale, isolated institution like Pennhurst, to provide the services and environment necessary for development and growth. After extensive expert testimony—including *amici's*—about the available alternatives to institutions like Pennhurst, the district court ordered that all Pennhurst inhabitants be removed from the institution, placed in appropriate, small-scale living arrangements in the community, and provided with necessary medical care, instruction and other services.

Although the district court's order was not rooted in the Bill of Rights Act, the district court's decision and remedy are consistent with this Act. The Bill of Rights Act is an international milestone in the advancement of the human rights of the mentally retarded. With its passage, Congress joined the growing international consensus that retarded persons cannot be consigned to large custodial institutions. Instead, Congress recognized that retarded persons have a right to "habilitation"—to the education, training, and care necessary for them to reach their maximum potential. 42 U.S.C. § 6010(1). Equally important, Congress specifically provided that such habilitation "should be provided in the setting that is least restrictive of the person's personal liberty." 42 U.S.C. § 6010(2).[1]

The findings and order of the district court exactly parallel Congress's findings and mandate in the Bill of Rights Act. Both the court and Congress explicitly found that *all* retarded persons—including the severely and profoundly retarded—can develop and grow. Both the court and Congress found, after hearing from the experts, that large, isolated institutions for the mentally

[1] The briefs of respondents and other *amici* will focus more specifically on the congressional mandate of the Bill of Rights Act. Present *amici* will primarily comment instead on the professional and scientific findings which underlie the district court's determination that large-scale institutions like Pennhurst must be rejected in favor of community-based living arrangements for the retarded.

retarded are cruel and inadequate anachronisms. Both the court and Congress mandated that mentally retarded people receive appropriate, individualized, community-based services.

The district court's order was compelled by both the record before the court and Congress's legislative findings. However, in a brief filed in this Court, *amici* Congress of Advocates for the Retarded, Inc., *et al.* (hereinafter "COA") present arguments which are supported neither by the trial record nor by the congressional findings. Nor is there justification for COA's implied suggestion that this Court remake a policy decision already made by Congress.

The conclusions of Congress and the district court are amply supported by a wealth of studies and scientific materials, including some of the very sources cited in the COA brief. Present *amici* will confine their arguments to the body of expert knowledge contained in the legislative and judicial record properly before this Court, all of which demonstrate that the district court's order faithfully implements the congressional findings embodied in the Bill of Rights Act.

I. Both the Courts Below and Congress Correctly Found that All Retarded People Can Develop and Grow in an Appropriate Environment.

The district court's findings in this case are based on an extensive record encompassing 32 days of trial and numerous depositions and other proceedings. The trial alone included testimony from more than 10 experts and numerous Pennhurst officials, employees, and residents; over 100 photographs; a 3-hour videotape film; 288 documentary exhibits; and a statistical and qualitative analysis of a systematic sample of 10% of Pennhurst's records on all of its residents.

A substantial part of the district court proceedings was devoted to evidence concerning the nature of mental retardation. This evidence showed that retarded people

are not fundamentally different from the rest of us. They "are more like normal people than they are dislike normal people . . . [They] have the same ability to love, to hate, to feel joy, pain, sorrow as you and I." J. App. at A310.[2] The record further establishes that retarded people are not mentally ill or diseased, but only that "the development of some of their abilities to do things is at a slower rate than we would normally expect." J. App. at A340. The court accordingly concluded that mental retardation is not a sickness, but an "impairment in learning capacity and adaptive behavior." *Halderman* v. *Pennhurst State School & Hospital*, 446 F. Supp. 1295, 1298 (E.D. Pa. 1977), *aff'd in part, rev'd and remanded in part*, 612 F.2d 84 (3rd Cir. 1979).

As an important corollary, the district court also concluded that "the level of functioning of *every* retarded person may be improved." 446 F. Supp. at 1298 (emphasis added). The COA erroneously argues that this corollary was based on the district court's misconception about the level of retardation at Pennhurst. In fact, the district court explicitly acknowledged that 74% of Pennhurst's residents are "severely to profoundly retarded." *Id.* at 1302. Based on unanimous expert testimony, the trial court still recognized the accepted scientific fact that all retarded persons—*including the severely and profoundly retarded*—can improve and develop.[3] *Id.*

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[2] Appendix references cited to the Joint Appendix of all parties are cited "J. App. at X" and refer to pages numbered A241-A1166. Appendix references cited to the State and County Petitioners' Joint Appendix to the Petitions for Writs of Certiorari filed in Nos. 79-1404, 79-1408 and 79-1415 are cited "J. App. at X" and refer to pages numbered 1a-240a. The district court transcript is cited "Tr. at X."

[3] This capacity to improve is what experts mean in describing retardation as an educational problem. J. App. at A249. They do not mean, as the COA suggests, that the fundamental conditions of retardation can be eliminated merely by providing education. *See* Brief for *amici curiae* COA (hereinafter "COA Brief") at 6.

at 1311. *See* J. App. at A252-62, A266, A310-12, A469-76, A544-49, A631-34, A707-09. The court of appeals concurred with this holding, explaining that "[w]hile the mentally retarded do suffer educational difficulties, the level of their functioning can be improved by individualized training." *Halderman* v. *Pennhurst State School & Hospital*, 612 F.2d 84, 92 (3rd Cir. 1979).

The COA characterizes this finding as "divorced from reality," COA Brief at 6, by asserting that profoundly retarded persons have a mental age of 2 to 2½ years. In implying that such individuals can never learn skills beyond those of a normal two-year-old, the COA misleads the Court.[4] As the district court record shows, mental age refers to a person's *rate* of intellectual growth, not its absolute limit. A person who remains at a mental age of two for many years can master skills far more sophisticated than those of a two-year-old child. He merely masters them at a slower rate. As Dr. James Clements, the former President of the American Association of Mental Deficiency and Chairman of the court-appointed Willowbrook Review Panel, explained at trial, "[S]aying that the intellectual capacity has been reached does not mean that I can't continue to learn, but [that] I can't learn at a higher or more efficient rate than what has already been developed." J. App. at A311-12. As the courts below and other courts have concluded, "Without exception, expert opinion indicates that: 'all mentally retarded persons are capable of benefitting from a program

[4] The suggestion of COA that abnormal behavior is a condition necessarily associated with mental retardation is likewise misleading. COA Brief at 5. Abnormal behavior is largely a result of the environment in which the individual is placed. J. App. at A254-60, A274-75. The evidence at trial showed that the abnormal behavior exhibited by residents of institutions is largely a function of the boredom and sensory deprivation which is generally associated with institutional environments. *Id.* Interestingly, these responses to boredom and sensory deprivations are not unique to retarded persons. Many studies indicate that restrictive institutional environments have devastating effects on *all* people. J. App. at A59-60.

of education and training.'" *Pennsylvania Ass'n for Retarded Children* v. *Pennsylvania*, 343 F. Supp. 279, 296 (E.D. Pa. 1972).[5]

This understanding of the nature of mental retardation is a fundamental premise of the Bill of Rights Act. In considering and passing the Act, Congress specifically rejected views such as those advanced here by COA, that retarded people are ill, that they require indefinite custodial care, and that they are "eternal children" incapable of development. S. REP. No. 160, 94th Cong., 1st Sess. 28 (1973) (hereinafter cited as S. REP. No. 160). *See* J. App. at A251-53. Instead, based on overwhelming evidence and findings, Congress accepted the developmental model of retardation which "stresses that all developmentally disabled individuals have potential for learning and growth." S. REP. No. 160 at 28. Indeed, Congress could not have repudiated the COA position more clearly:

> Developmentally disabled persons for too long have been cast into a number of destructive models which have been used as justification for their rejection and exclusion from the mainstream of society. Some of these models are still prevalent today. They include the view that developmentally disabled persons are sub-human organisms; that they are lacking in many of the needs, aspirations and sensitivities of other human beings.
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> [*T*]*he assumption that certain individuals are essentially incapable of development . . . must be rejected.* [*Id.* at 27-28 (emphasis added)]

Based on these legislative findings, Congress specifically provided in section 6010(1) of the Bill of Rights Act

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[5] *See* 446 F. Supp. at 1298; 612 F.2d at 92; Welsch v. Likins, 373 F. Supp. 487, 495 (D. Minn. 1974) (every retarded person, "no matter what the degree or severity of retardation, is capable of growth and development if given adequate and suitable treatment"); Naughton v. Bevilacqua, 458 F. Supp. 610, 614-15 (D.R.I. 1978), *aff'd*, 605 F.2d 586 (1st Cir. 1979).

that all retarded persons have the right to "habilitation." "Habilitation," as defined by the district court, means the "education, training and care required by retarded individuals to reach their maximum development." 446 F. Supp. at 1298.[6]

As the evidence before the district court showed, education and training alone do not provide effective habilitation. Instead, habilitation requires that the environment in which a retarded person is placed be designed to increase the skills of the developing individual. *See* J. App. at A260-61. *See also* J. App. at A311. The person must have sensory stimulation, personal interaction, and the opportunity to use the skills he acquires. J. App. at A258-59. In order to develop, retarded persons—like all persons—must also be challenged. Habilitation programs, such as speech therapy and training in personal and social skills, are part of the environment which influence development. They do not, however, comprise the total environment. In fact, these programs cannot be effective unless the person's surroundings reinforce these skills and encourage him to increase his capacities.

Both Congress and the district court thus recognized that habilitation can only be realized through "normalization." "Under the principles of normalization, the retarded individual is treated as much like the non-retarded person as possible. . . . The basic tenet of normalization is that a person responds according to the way he or she is treated." 446 F. Supp. at 1311.[7] Normal people in

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[6] *See also* Wyatt v. Stickney, 344 F. Supp. 387, 395 (M.D. Ala. 1972), *aff'd in part, remanded in part, sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

[7] COA improperly defines normalization. It argues that normalization is merely the indoctrination of individuals to exhibit socially acceptable behavior and does not include maximization of intellectual potential, independence, or happiness. COA Brief at 10 n.14. As the testimony of former Pennhurst residents themselves shows, p. 21, *infra*, the principle of normalization as embodied in community living arrangements can enhance a retarded person's life

their daily environments are exposed to a wide variety of opportunities and stimuli which are the prerequisite of growth for all people. Placing retarded individuals in an environment as much as possible like that of a normal person will ensure that developmentally disabled persons too have the opportunity to partake of the richness of the world and to develop in response to it.

The corollary of habilitation and normalization, therefore, is the concept of placing retarded people in the "least restrictive environment." As Congress found:

> A final, but critically important dimension of this new model [the developmental model] is that developmentally disabled persons should live like nondevelopmentally disabled persons to the greatest degree possible. Every effort should be made to assist developmentally disabled persons to maximize their ability for self-care and to live normal lives. From this, it also follows that each developmentally disabled person should be allowed to live in the least restrictive environment conducive to his or her maximum development. [S. REP. No. 160 at 28.]

Based on the foregoing findings and policy judgments, Congress also specifically provided in section 6010(2) of the Bill of Rights Act, that habilitation for all retarded persons "should be designed to maximize the developmental potential of a person and should be provided in the setting that is least restrictive of the person's personal liberty."

These twin congressional mandates—that retarded persons have the right to effective habilitation and to live in the least restrictive environment—prescribe the standards by which an institution like Pennhurst must be evalu-

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in a myriad of ways. Moreover, on the basis of the record, the district court found that "[t]he thrust of habilitation through normalization is the remediation of the delayed learning process so as to develop the maximum growth potential by the acquisition of *self-help, language, personal, social, educational, vocational and recreational skills*". 446 F. Supp. at 1311 (emphasis added).

ated. Measured against these standards, Pennhurst is indisputably a failure.

II. Both the Courts Below Correctly Found that Pennhurst Provides Neither Adequate Habilitation Nor an Appropriate Environment for its Residents.

Pennhurst is a product of an earlier era. *See* S. REP. No. 160 at 26-27; J. App. at A253-55. It was conceived at a time when retarded people were considered "defectives" to be segregated from society in totally sheltered environments, both for their own protection and the protection of others. *See* 446 F. Supp. at 1299-1300; S. REP. No. 160 at 26. It was built before society recognized that retarded individuals could develop and grow.

Pennhurst epitomizes the problem of "the tragic warehousing of human beings" which Congress sought to eliminate with the Bill of Rights Act. 121 CONG. REC. 16519 (1975). The overwhelming evidence in this case establishes that habilitation services are not provided at Pennhurst. Instead, the evidence shows that Pennhurst's residents suffer physical abuse and a decreased rate of development, and many have actually regressed from previous levels of achievement.

The appalling conditions at Pennhurst are documented in the record and described in the district court's findings, sometimes in gruesome detail. Pennhurst is unsanitary and unsafe. As the district court found: "There is often excrement and urine on wards floors . . ., and the living areas do not meet minimal professional standards for cleanliness. . . . Obnoxious odors and excessive noise permeate the atmosphere at Pennhurst." 446 F. Supp. at 1308. All living areas at Pennhurst violate the local safety code. J. App. at A821. At least 500 Pennhurst residents live in buildings which Pennhurst's own Superintendent recommended for demolition more than seven years ago. J. App. at A297.

Physical abuse of residents is commonplace. Residents are frequently attacked by other residents, subjected to

physical or chemical restraints, and occasionally battered by the staff. 446 F. Supp. at 1303-10. One expert at trial characterized a summary of accidents during a one-month period as a "battlefield report." J. App. at A290-91. All of the named plaintiffs in this case have suffered serious bruises and scratches, several have lost teeth, and one was hospitalized for two weeks because of head and face injuries he received as a result of a beating. 446 F. Supp. at 1309-10. Physical restraints and seclusion rooms are overused and inadequately monitored. *Id.* at 1306-07. In 1972, an eleven-year-old child strangled to death when tied to a chair in "soft restraints." *Id.* at 1307 n.36. Psychotropic drugs are used without proper monitoring. The use of drugs at Pennhurst does not even "meet minimally professional standards and is physically hazardous to the residents." *Id.* at 1308.

The district court found that the average resident receives less than eight hours of instruction or training per week. *See id.* at 1304. Currently, most residents receive no structured program on the wards designed to increase growth and development. Programs in feeding, showering, and toileting are sporadic and inconsequential. J. App. at A268, A318, A795-96. One hundred six residents are on the waiting list for speech therapy, and nearly every resident at Pennhurst could benefit from some type of communications program. 446 F. Supp. at 1305. Three hundred to four hundred residents presently need physical therapy to prevent physical deterioration, but less than 150 receive it. *Id.*; *see id.* at 1305 n.28. The overwhelming evidence led the court to conclude that "the retarded residents of Pennhurst have not received, and are not receiving, minimally adequate habilitation." *Id.* at 1318.

In addition to documenting the physical degradation and injuries inflicted at Pennhurst, the record shows that the institution has a debilitating psychological impact on residents. One expert testified, "These people have been here so long that they have given up hope." J. App. at

A577. The physical design of the building effectively confines weak and fragile residents to upper floors for years and "many reach a point where they'd rather not go downstairs." J. App. at A578. Residents are crowded into large, stark wards with no opportunity for privacy. They are fed, bathed and toileted in groups. J. App. at A414-15. The district court found that Pennhurst is "isolated," "restrictive," and "almost totally impersonal." 446 F. Supp. at 1303. The atmosphere at Pennhurst generates hostility. "Many of the residents of the cottages are confined for long periods of time," and such confinement "breeds aggression" which "is contagious. People hit one another and when a person gets hit, he hits back." J. App. at A578. Pennhurst's Director of Psychological Services concluded that the environment of Pennhurst has "a crippling effect on behavior, education, and attitudes." *Id.*

This crippling effect has tragic results. At trial, Dr. Clements testified that the "environment at Pennhurst is not conducive to acquiring new skills; indeed, it is more conducive to losing skills that one has already developed." J. App. at A318, A332. As a result, many residents have actually regressed at Pennhurst. A systematic sample of the institution's records revealed explicit notations of regression in the records of more than one-third of Pennhurst's residents. 446 F. Supp. at 1308 n.40. Dr. Clements explained that some individuals who enter Pennhurst able to speak are compelled by the never-ending noise and chaos to retreat into silence. J. App. at A317-18. Similarly, individuals who arrive toilet-trained may lose that capacity because facilities are either unavailable or improperly equipped. J. App. at A332. The district court thus concluded that "[m]any of the residents have suffered physical deterioration and intellectual and behavioral regression during their residency at Pennhurst." 446 F. Supp. at 1309; *see id.* at 1308, 1318; J. App. at A327, A329-30, A417-18.

III. Both the Courts Below and Congress Correctly Found that Large Institutions Like Pennhurst Inherently Cannot Provide an Appropriate Environment for Habilitation.

All the parties to this litigation and the courts below agreed that the conditions at Pennhurst are appalling. *See* 612 F.2d at 92. The critical issue presented in this case is what remedy is appropriate. One approach—apparently favored by COA—would be to try to improve Pennhurst itself. *See* COA Brief at 12-13. The trial record proves, however, that Pennhurst as an institution can never provide either an appropriate environment nor adequate habilitation.

Numerous experts were asked whether an improved Pennhurst would provide adequate habilitation. All said no. For instance, Dr. Alexander Hersh, a consultant and professor of sociology *retained by defendants themselves* to study Pennhurst and to recommend improvements, stated:

> We came to the conclusion that it could not, that there was no way that Pennhurst could be made into an adequate facility. It is simply too far beyond repair and there are just literally hundreds of reasons why this is the case, not the least of which is the fact that Pennhurst as the whole structure, the whole way of operating out there, is simply too far gone. It is simply based on an earlier model, which is just totally obsolete, so that the answer is no. [J. App. at A770.]

This same evaluation was echoed by Dr. Valaida Walker, who had worked with Dr. Hersh in evaluating Pennhurst for the defendants. Dr. Walker testified that the team assigned to determine how to improve Pennhurst concluded instead that should it be closed. "Money spent to upgrade the programs and to upgrade the buildings," Dr. Walker explained, "would just be money down the drain." J. App. at A780.

All parties to this litigation agreed that Pennhurst is a segregated, isolated, inflexible, and depersonalized en-

vironment, presenting few opportunities for residents to develop positive relationships with other people or to practice acquired skills. J. App. at A414-16. Moreover, these conditions at Pennhurst cannot be dismissed as the result of some unique combination of circumstances. They are not the result of a cruel or insensitive staff—the experts complimented the dedication of the staff. *See* 446 F. Supp. at 1324. They are not the result of a unique resident population—the resident population at Pennhurst parallels the population at large institutions across the country. SCHEERENBERGER, PUBLIC RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED 12 (1976) They are not the result of insubstantial expenditures—the per capita cost at Pennhurst is among the highest for any large institution of its type. J. App. at 44a ($60 per day). *See* Butterfield, *Some Basic Changes in Residential Facilities*, in PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, CHANGING PATTERNS IN RESIDENTAL SERVICES FOR THE MENTALLY RETARDED 15, 22-23 (rev. ed., Kugel & Shearer, eds., 1976). There is no reasonable basis on this record to believe that Pennhurst can be improved sufficiently to provide adequate habilitation.[8]

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[8] The reason institutions like Pennhurst can never provide an environment for adequate habilitation was identified by Dr. Gunnar Dybwad. Dr. Dybwad, who devoted himself for years to improving institutions and who described himself as "an institution man since 1929," explained how he came to realize the inherent inadequacy of institutions:

> Interestingly, it wasn't the bad conditions and our inability to do much about them which have changed my mind, but it has been the repeated and even more impressive demonstration by children and adults with mental retardation of their capacity to live and grow, once we keep them free of the depressing institutional-looking environment.
>
> You see, as long as I could blame the bad conditions on the institutions my energy and that of my colleagues was geared to two remedies—carpeting, better wall covering, all of these things, more staff; but now our energy is really directed to the creation of liberating humans and humane environments in the community with the final objective of closing down institutions. [J. App. at A549.]

Several major empirical studies mentioned in the record have compared large-scale institutions, varying in size from 121 to 1650 residents, with group homes varying in size from 7 to 41 residents in the United States, England and Scandinavia. These studies showed that the quality of life in large institutions, regardless of their size or resident-staff ratios, was uniformly inadequate. In contrast, all group homes were found to be significantly more resident-oriented than any of the large-scale institutions. The group homes were characterized by significantly less rigidity of routine, less regimentation of residents, less depersonalization, and significantly more interaction between staff and residents.[9]

Not only the experts but also the residents condemn institutions like Pennhurst. At trial, one expert described the results of a seminar that he conducted with severely retarded persons to determine what they thought of their institutional environments and what alternatives they would prefer. Given the choice between an institutional environment and a community living situation, these persons consistently preferred the latter. The expert explained that the residents expressed a desire "for privacy"—to live elsewhere than "in the enormous ward with a lot of others." Tr. at 4-104. *See* J. App. at A295. He reported that, "without exception" the residents tended to express "a fear" of the institution: "They were just afraid that they were dominated by something bigger than them, and they wanted to move down the scale to something they could cope with." *Id.*

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[9] These studies, which were described in the testimony of Drs. Dybwad and Lancaster-Gaye, J. App. at A422-23, A549-51, are set forth in KING, RAYNES & TIZARD, PATTERNS OF RESIDENTIAL CARE: SOCIOLOGICAL STUDIES IN INSTITUTIONS FOR HANDICAPPED CHILDREN (1971) (England); McCormack, Balla & Zigler, *Cross-Institutional, Cross-Cultural Study*, 80 AM. J. OF MENTAL DEFICIENCY 1-17 (1975) (United States and Scandinavia); and Kushlick, *Wessex, England* in PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, CHANGING PATTERNS IN RESIDENTIAL SERVICES FOR THE MENTALLY RETARDED, 297-312 (rev. ed., Kugel & Shearer, eds., 1976).

The district court's conclusion that Pennhurst does not and cannot provide adequate habilitation for its residents, reflects similar conclusions reached by Congress in the Bill of Rights Act about institutions like Pennhurst. Congress heard a great deal of testimony about the conditions at Willowbrook in New York, Partlow in Alabama, Rosewood in Maryland, and numerous other institutions similar to Pennhurst. *See, e.g., Hearings on S427 and S458 before the Subcommittee on the Handicapped of the Senate Committee on Labor and Public Welfare*, 93d Cong., 1st Sess. 230 (1973). It also heard testimony that attempts to improve these institutions have repeatedly proved unsuccessful. *See id.* at 30; 121 CONG. REC. 16516 (1975).[10]

Thus, the Senate Labor and Public Welfare Committee found that "[m]any of these institutions *by their nature*, their size, their isolation, their impersonality, *are unsuitable* for treatment, education, and habilitation programs." S. REP. NO. 160 at 33 (emphasis added). As the Committee Chairman noted in the closing floor debate on the Bill of Rights Act, "The abuses are too commonplace to point at a single institution, or a single abuse and say that it is an anomaly." 121 CONG REC. at 16516-17. Large institutions like Pennhurst simply cannot provide adequate habilitation.

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[10] Indeed, the federal court in the Willowbrook case, after extensive efforts at institutional reform, found that the "goals of normalization and development of the mentally retarded cannot be met until every effort is made to physically and socially integrate the class members into the community." New York State Association for Retarded Children v. Carey, No. 72-C-356/357, Memorandum Decision and Order, slip op. at 11 (E.D.N.Y. June 10, 1977).

IV. Both the Courts Below and Congress Found that Necessary Habilitation Can Be Provided Only Through Community-Based Services.

A. *The District Court Record Shows that Community Living Arrangements Are Flexible and Can Be Tailored to Individual Needs.*

The district court prescribed the remedy in this case after hearing extensive testimony about the alternatives to monolithic institutions like Pennhurst. This testimony depicted the wide variety of small-scale, personalized, community-based services which are frequently termed "community living arrangements."

One witness described the system of services available in Nebraska, which is much like the network in Pennsylvania. J. App. at A928-42, A983, A1029. The diverse Nebraska system includes, for example, group residences for six to eight persons, and even smaller residential arrangements such as foster homes. It also encompasses a wide spectrum of vocational training programs, including in-home training services and integrated preschools attended by both retarded and non-retarded children. *Id.*

Pennsylvania's community living programs, too, reflect a variety of alternatives. These alternatives include, for example, an infant motivation program providing three to four hours of daily instruction for profoundly retarded children living in their natural homes, and a counseling and support plan for three moderately retarded adults living in an apartment and working in the community. J. App. at A450-68. *See also* J. App. at A496-505.[11]

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[11] For a description of other forms of community living arrangements, *see* Herr, *Civil Rights, Uncivil Asylums, and the Retarded*, 42 U. CIN. L. REV. 679, 765-769 (1974); Glenn, *The Least Restrictive Alternative in Residential Care and the Principal of Normalization*, in PRESIDENT'S COMMITTEE ON MENTAL RETARDATION, THE MENTALLY RETARDED CITIZEN AND THE LAW 499-514 (M. Kindred, *et al.* ed. 1976).

The testimony at trial refutes COA's suggestion that retarded persons with heterogeneous needs, who are placed in small-scale community living arrangements, cannot receive the highly specialized services they need. COA Brief at 15-16. In fact, because of the scale, flexibility and access to community resources provided by community living arrangements, such people can obtain a more sophisticated and extensive range of services than in any isolated, monolithic institution. "Can you imagine setting up [in] an institution serving 1200 or 1500 persons, a medical facility of the type of quality that one can find in a major city like Philadelphia?" asked one expert at trial. "It simply can't be done." J. App. at A708-09. *See also* Tr. at 5-135, 5-143.

Community living arrangements do not entail, as COA argues, simply treating retarded people "as if they were already normal." COA Brief at 14. The community-based services ordered by the district court are designed to treat a retarded person "as much like the non-retarded person *as is possible.*" 446 F. Supp. at 1311 (emphasis added). As the trial testimony made clear, a community living arrangement designed for profoundly retarded people will not allow these people to starve in the aisles of the local grocery store. *See* COA Brief at 5. In addition to providing such people with necessary nourishment, however, it might also afford them the opportunity, with proper supervision, to explore the neighborhood grocery store. A community living arrangement structured for severely retarded people will not force such individuals to negotiate public bus systems, if they are incapable of doing so. However, it might provide them with carefully sequenced instruction in which they are accompanied on public buses until they learn specific routes. *See* J. App. at A614-15. A community living arrangement structured for mildly retarded individuals will not place such people in a local educational program unsuited to their needs. However, it might allow such children to attend classes in a neighborhood school providing specialized instruction

for the developmentally disabled. *See* J. App. at A471-A509, A530-32, A687. As the trial record thus illustrates, community-based programs facilitate individualized, flexible habilitation.

Moreover, because of their flexibility and use of existing community resources, community living arrangements are a generally less expensive mode of care than warehousing mentally retarded persons in large institutions like Pennhurst. On the basis of the evidence, the district court concluded that the cost of running Pennhurst in 1976, excluding the fair rental value of the buildings, averaged $60 per resident per day. The statewide cost of community living arrangements in Pennsylvania in the same year was $17.64 per resident per day, plus $10 per day for care and instruction for one-third of such persons. 446 F. Supp. at 1312. Moreover, the trial court's findings were based on the current costs of Pennhurst and not on costs which would be incurred if proper medical and habilitation services were provided.

B. *The District Court Record Shows that Community-Living Arrangements—Unlike Large-Scale Institutions—Can Successfully Provide Habilitation for All Retarded People.*

Community-based habilitation programs are not only individualized and flexible; they are also highly successful for all mentally retarded persons. The experts testifying about community living arrangements agreed that such alternatives immeasurably improved the lives of persons who had previously been condemned to large-scale institutions like Pennhurst. One expert at trial, for example, described a comprehensive survey of people transferred from a large Nebraska institution into community-based programs. This study analyzed individuals' movement from more highly structured community living arrangements to less highly structured arrangements, and their development of skills such as speech, personal hygiene, and physical mobility. The study unequivocally demonstrated "quite a rapid progress of individuals after

they left the institutional services." J. App. at A488-89. In fact, most of the 135 adults who had to be placed in a highly structured residential setting after leaving the institution were able to transfer to a semi-independent setting in just two years. Many of the children who were on liquid diets because they could not chew or swallow when they left the institution were eating regular food independently in just two years. *Id.*

The results of the Nebraska survey are not unusual. For example, one expert interviewed former Pennhurst residents who had been placed in community living arrangements. She concluded that these individuals, like those in Nebraska, were rapidly progressing toward more independent living arrangements and improving their skills. J. App. at A504-06. Another witness described a foster and group home system in Michigan in which profoundly retarded and highly handicapped individuals are placed in local homes. The system is so successful that there are virtually no new admissions to the regional large-scale institutions. J. App. at A552-54.

In addition to professionals in the field, mentally retarded people and their families attested at trial to the success of community-based habilitation. For example, Mrs. Grace Auerbach reported that her son had learned more in three and one-half years in the community than in his 38 years at Pennhurst. He is now able to talk, walk, work, and keep his own bank account. J. App. at A612-16. Robert Troester, who is now living in a group home, poignantly contrasted his experience at Pennhurst with the dignity of his new life. At Pennhurst "there's too many fights, too many arguments, too many stealings going on and all that, robberies, undesired things. . . . I used to do bad things too, but now I changed myself. I am a different kind of man now." J. App. at A594. *See also* J. App. at A595, A603, A609.

In addition, contrary to COA's claim, the record demonstrates that community living arrangements can benefit even profoundly retarded people and those with

multiple handicaps and significant medical needs. For example, one expert testified that when she initiated Nebraska's pioneer program in community living arrangements, she was concerned about taking "severely, profoundly retarded, multiple handicapped, medically complex" people out of the large-scale institutions. J. App. at A480. Nevertheless, the program provided such people much more complete and individualized care than they had previously received, and the improvement of such persons' health and skills—including the ability to express themselves—was dramatic. J. App. at A480-86, A488-95. *See also* J. App. at A931. Indeed, another expert testified that the profoundly and severely retarded benefit *most* from a small-scale community living arrangement, since "what they need basically is a small stimulating environment where their physical needs receive attention." J. App. at 551-53. As the trial court concluded, based on an extensive record, all of Pennhurst's residents can benefit from appropriate placement in community-based living arrangements.

This success record of community living arrangements completely refutes COA's suggestion that small-scale community living arrangements isolate retarded people in a hostile and unaccepting world. COA Brief at 15. Extensive testimony at trial established that deinstitutionalized mentally retarded persons interact with and are accepted by the communities in which they live and work. For example, in Nebraska, when even children with multiple handicaps are placed in normal pre-schools,

> the kids would interact with all the normal kids and the normal kids would interact with the handicapped children also and we found phenomenal growth—we also found that the normal kids love it. It is another old myth that the non-handicapped kids will not accept the handicapped kids. [J. App. at A472-73.]

Similarly, the mother of a former Pennhurst resident testified that although she initially opposed her son's release from Pennhurst, when she saw his outstanding

progress outside the large-scale institutional setting, she was delighted with his return to the community. J. App. at A617-20. *See also* J. App. at A684-694.

In fact, contrary to COA's suggestion, the district court record demonstrates that community living arrangements provide human interaction and supportive peer group relations which are unavailable at institutions like Pennhurst. The size, impersonality, and lack of services at Pennhurst makes residents physically abusive of themselves and of their peers. J. App. at A255. When placed in community-based programs, however, these same people cease such violent and antisocial behavior. J. App. at A463-64. Many persons responded to the cacaphony and hostility of Pennhurst by retreating into silence and simply refusing to talk or communicate with anyone. J. App. at A578, A255. These very same people, when placed in the so-called hostile real world, exhibited rapid improvement and willingness to use communication and social skills. J. App. at A688-90, A317-18.

This contrast between institutional and community-based environments illustrates the truly "less restrictive" nature of the successful habilitation offered by community living arrangements. The district court decision in this case does not suggest that retarded people be released without supervision or supportive services. The court properly recognized, however, that through the integrated, individually tailored habilitation possible in community-based programs, retarded persons can attain some measure of control over their lives. They can enjoy opportunities to interact with different kinds of people, to participate in the world around them, to make many of the simple, everyday decisions that ordinary people make, and to achieve a previously unknown sense of happiness and dignity. In short, they can experience the personal development and true liberty which institutions like Pennhurst cruelly preclude.

C. *The District Court's Specific Remedy Exemplifies the Effective Community-Based System of Services Mandated by Congress in the Bill of Rights Act.*

The district court ordered the transfer of Pennhurst residents into appropriate community living arrangements providing individualized habilitation. The district court's order is thorough and careful. All Pennhurst residents are to be placed in "suitable community living arrangements" as soon as it is "certain that each and every retarded resident who is moved from Pennhurst can be accommodated in a community facility which will provide minimally adequate habilitation." 446 F. Supp. at 1325 and 1326. The defendants below, in conjunction with this placement procedure, must "develop and provide a written individualized program plan, formulated in accordance with professional standards." *Id.* at 1326. They must also "provide all necessary and proper monitoring mechanisms to assure that community living arrangements and other community services of the necessary quantity and quality are provided and maintained." *Id.* Finally, they must recruit and train a "sufficient number of qualified community staff" to prepare individual exit and community plans for each Pennhurst resident, and then to "develop, maintain, and monitor" the community living arrangements required. *Id.* at 1327.

While, as COA argues, a standardless, sloppily designed and inadequately monitored community living arrangement system might fail, COA Brief at 20, the remedy ordered in this case will not. The district court's remedy contains all the requirements identified by the experts at trial for successfully providing habilitation in the community. *See* J. App. at A497-509. *See also* COMPTROLLER GENERAL OF THE UNITED STATES, RETURNING THE MENTALLY DISABLED TO THE COMMUNITY (Report to the Congress 1977). The court's order foresees the creation of a coordinated, individualized, carefully monitored, and professionally staffed system of community-based services, which will build upon Pennsylvania's already highly suc-

cessful network of community living arrangements. Moreover, the court appointed a Special Master to execute the specific requirements of its order. The Master is now drafting implementation plans for each county in Pennsylvania. These plans detail procedures for placing residents in the appropriate community arrangement, providing them with necessary services, and evaluating their progress. Moreover, the Master is surveying the community living arrangements and other services currently available in each county and ascertaining what additional residences and resources must be developed. Finally, she is estimating the costs of implementation and is projecting, for each county, a timetable for the establishment of the new services which will be needed by former Pennhurst residents. *See, e.g.*, Special Master's Draft Plan, Bucks County (1979).

The district court's remedy is precisely the type of replacement for large-scale institutions which the Bill of Rights Act mandates. Congress recognized that effective deinstitutionalization is required to provide "treatment, services, and habilitation" in the setting that is "least restrictive of the person's personal liberty." 42 U.S.C. § 6010 (1) and (2):

> It must be recognized that the vast majority of developmentally disabled persons and the vast majority of persons now institutionalized should not be in these institutions at all. Efforts to assure proper treatment, education and habilitation services in large institutions should not deflect attention from the fact that most of these institutions themselves are anachronisms, and that rapid steps should be taken to phase them out. Many of these institutions by their very nature, size, their isolation, their impersonality, are unsuitable for treatment, education, and habilitation programs. [S. REP. No. 160 at 32.]

Therefore, Congress mandated the "development of community alternatives," *id.* at 33, and this is precisely what the district court ordered.[12]

COA argues that a "widespread movement to [community living arrangements] from large institutions . . ., which are subject to public oversight and constitutional standards," COA Brief at 21, is undesirable. This argument is misconceived. The evidence at trial established that "public oversight and constitutional standards" have been wholly inadequate to ensure the residents of Pennhurst and similar facilities with habilitation and a growth-inspiring environment. More importantly, Congress adopted the overwhelming concensus of the experts that retarded citizens can no longer be isolated in large-scale institutions, and accordingly made the policy decision that large-scale institutions must be replaced with smaller scale, more personalized community care.

CONCLUSION

In some quarters, of course, doubts about deinstitutionalization remain. Even well-meaning friends and relatives of retarded persons may hold traditional prejudices that no mentally retarded person has the capacity to live in the community. Institutional staff and their unions may oppose deinstitutionalization because of "concern with jobs, status, job security and job opportunities." J.

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[12] Indeed, Congress itself has taken steps to ensure the continued success of community-based habilitation. Federal legislation enacted over the last 15 years provides federal suport for localized educational, medical, vocational and other services for handicapped and retarded people. *See* the Rehabilitation Act of 1973, 29 U.S.C. § 701 *et seq.*; The Education for All Handicapped Children Act of 1975, 20 U.S.C. § 1401 *et seq.*; and the Social Security Act, Titles XIX and XX, 42 U.S.C. §§ 1396d(d), 1397. The existence of federally-subsidized community programs has made it easier for society to reintegrate the mentally retarded into the community and still provide habilitation services. J. App. at A706-07.

App. at A568-69.[13] These doubts and fears, however, cannot justify alteration of the order below. COA simply cannot now remake the trial court record establishing the appropriateness of the court's deinstitutionalization remedy in this case. Nor can they overturn in this Court the fundamental policy decision made by Congress that all retarded persons have a right to true habilitation in the least restrictive setting.

For the foregoing reasons, the judgment of the court of appeals should be affirmed except insofar as it fails to mandate the deinstitutionalization of all Pennhurst residents.

Respectfully submitted,

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[13] Such concerns apparently are felt by COA. *See* COA Brief at 19 (discussion of job conditions, salaries, and absence of "career ladder" if deinstitutionalization takes place). *See also* Note, *Implementation Problems in Institutional Reform Litigation*, 91 Harv. L. Rev. 428, 433 (1977).

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IN THE

Supreme Court of the United States

October Term, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, et al.,
Petitioners,

v.

TERRI LEE HALDERMAN, et al.,
Respondents.

On Writs of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF OF AMICI CURIAE, NATIONAL ASSOCIATION FOR RETARDED CITIZENS, UNITED CEREBRAL PALSY ASSOCIATIONS AND EPILEPSY FOUNDATION OF AMERICA IN SUPPORT OF AFFIRMANCE

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Halderman v. Pennhurst, 446 F. Supp. 1295 (E. D. Pa. 1977), aff'd. 612 F. 2d 84 (1979) 6, 7, 10, 12, 20, 21, 22, 26

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Jackson v. Bishop, 404 F. 2d 571 (8th Cir. 1968) 19

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Mills v. Board of Education, 384 F. Supp. 866 (D. D. C. 1972) 10

New York State Association for Retarded Citizens v. Carey, 393 F. Supp. 715 (E. D. N. Y. 1975) 29, 40

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Wyatt v. Stickney, 344 F. Supp. 387 (M. D. Ala. 1972), aff'd in part, remanded in part and decision reserved in part sub nom. Wyatt v. Aderholt, 503 F. 2d 1305 (5th Cir. 1974) 15, 16, 23

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Social Services Amendments of 1974, 42 U. S. C. § 1387 et seq. 5, 47

TABLE OF CITATIONS (Continued)

Other Federal Materials: Page

S. Rep. No. 94-160, 94th Cong., 1st Sess. 546 (1975) 7, 8, 11

1970 U. S. Code Cong. and Adm. News 4717 .....11, 27

State Materials:

In the Matter of Stefanie L., J. No. 184929 (Pa. C. P. Phila. County, Juv. Div. June 30, 1977) 21

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Juvenile Act of 1972, 11 P. S. § 50-101 et seq. (Pa.) 22

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V. A. M. S. § 202.193 (Missouri) 24

West Ann. Welf. and Inst. Code § 4500 et seq. (California) .. 23

Other Authorities:

B. Baker, G. Seltzer, M. Seltzer, *As Close as Possible, Community Residences for Retarded Adults* (1977) 16, 17

J. Cass, "New Life for the Severely Retarded," *The Philadelphia Inquirer,* August 3, 1980 at 1A, col. 2 .....12, 15

Carver, J. N., and Carver, N. E., *The Family of the Retarded Child* (1972) 13

C. Cherington, "Community Life and Individual Needs," *New Neighbors, the Retarded Citizen in Quest of a Home* 3 (President's Committee on Mental Retardation, 1974) .. 5, 6

Costs of Services for Willowbrook Class Clients in Community Placement, Metropolitan Placement Unit (New York State Department of Mental Hygiene, September, 1977) 24

G. Dybwad, *Challenges in Mental Retardation* (1964) 9

R. Frohboese and B. Sales, "Parental Opposition to Deinstitutionalization: A Challenge in Need of Attention and Resolution," 4 Law and Human Behavior 1 (1980) 14

TABLE OF CITATIONS (Continued)

Other Authorities (Continued): Page

T. Gilhool, "The Right to Community Services," *The Mentally Retarded Citizen and the Law* 173 (The President's Committee on Mental Retardation, 1976) 9, 26

L. Glenn, "The Least Restrictive Alternative in Residential Care and the Principle of Normalization," *The Mentally Retarded Citizen and the Law* 499 (The President's Committee on Mental Retardation, 1976) 17, 24

E. Gollay, R. Freedman, M. Wingaarden, N. Kurtz, *Coming Back, the Community Experiences of Deinstitutionalized Mentally Retarded People* (1978) 5, 12, 13, 16, 26, 30

C. Halpern, "The Right to Habilitation," *The Mentally Retarded Citizen and the Law* 385 (The President's Committee on Mental Retardation, 1976) 16

"Handicapped Children's Education Project, A Summary of Issues and State Legislation Related to the Education of Handicapped Children in 1972," 1 Report No. 36 of the Education Commission of the States (1973) 26

N. King, "Rights of the Mentally Retarded," 57 N. C. L. Rev. 336 (1979) 9

B. Lensink, "One Service System at Work" in *New Neighbors, The Retarded Citizen in Quest of a Home* 105 (President's Committee on Mental Retardation, 1974) 17

"Living Arrangements for People with Life Long Disabilities," Temple University Sugarloaf Conference Center (February 13-17, 1977) 17, 25

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M. Minge and T. Ball, "Teaching of Self-Help Skills to Profoundly Retarded Patients," 71 *Am. J. of Mental Deficiency* 846-68 (1967) 9

B. Nirje, "A Scandinavian Visitor Looks at U. S. Institutions," R. Kugel and W. Wolfensberger (eds.), *Changing Patterns in Residential Services for the Mentally Retarded* 51 (1969) 6, 9

TABLE OF CITATIONS (Continued)

Other Authorities (Continued): Page

B. Nirje, "The Normalization Principle and its Human Management Implications," R. Kugel and W. Wolfensberger (eds.), *Changing Patterns in Residential Services for the Mentally Retarded* 179 (1969) 9

G. O'Connor, *Home is a Good Place: A national perspective of community residential facilities for developmentally disabled persons* (1972) (Monograph of the American Association of Mental Deficiency, No. 2) 12, 17

Plan for Placements, N. Y. City Long Island County Service Group Office (December 1, 1978) 16

B. Willer, J. Intagliata, and A. Atkinson, "Deinstitutionalization as a Crisis Event for Families of Mentally Retarded Persons" (1975) (Unpublished report of study assisted under Department of Health, Education, and Welfare, Region II, Office of Human Development, Developmental Disabilities Office, Grant N. 50P10568/2) 14, 15

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"*Wyatt,* Willowbrook Studies Evaluate Success of Community Placement," 2 *Mental Disability Law Reporter,* 422 (1978) 16

E. Zigler, D. Balla, "Impact of Institutional Experience on the Behavior and Development of Retarded Persons," 82 *Am. J. of Mental Deficiency* 1 (1977) 6, 7

INTEREST OF AMICI CURIAE

The National Association for Retarded Citizens (formerly the National Association for Retarded Children) is the only national voluntary organization devoted solely to improving the welfare of *all* mentally retarded children and adults without regard to race, creed, geographic location or degree of handicap. It provides help to parents and other affected individuals, organizations, and communities in jointly solving the problems caused by retardation.

Organized in 1950 by a handful of parents and friends of mentally retarded persons, by 1977 the Association had grown to more than 250,000 members affiliated with some 1,900 state and local member units located across the nation and in United States territories and military installations abroad.

NARC is primarily a "grass roots" organization emphasizing services and advocacy at the local level, although it has both state and national components. The latter has a Research and Demonstration Institute for the development of more effective and humane ways of responding to individuals with mental retardation.

The United Cerebral Palsy Associations, Inc., is a nationwide network of voluntary community agencies serving the lifetime needs of children and adults with cerebral palsy and their families. Founded in 1948, it has 261 state and local affiliates. About sixty percent of cerebral palsy victims suffer from some form of mental retardation and between ten and fifteen percent are severely retarded.

UCPA's goals are two-fold: to prevent cerebral palsy and to help disabled people shape their lives by their abilities rather than their disabilities. To these ends, the organization sponsors scientific research and professional training, provides direct services to individuals, seeks to educate the public about cerebral palsy, and takes an ad-

vocate's role on behalf of disabled persons denied their civil and legal rights.

The Epilepsy Foundation of America is a non-profit corporation founded in 1968 to advance the interests of the two million Americans with epilepsy through research, vocational programs, legal advocacy and professional awareness and public education programs. EFA has a long standing interest and commitment to secure the legal rights of persons with epilepsy and other neurological disorders through the development of legal principles based on current medical and psychological concepts, rather than on stereotypical prejudices against people with neurological disorders. As a result of its experience in protecting the rights of persons with epilepsy, EFA has expanded its scope to join in the aid of persons suffering from other neurological disorders and enduring many of the same unnecessary disabilities.

These organizations present this *amicus* brief on behalf of the plaintiffs herein because they believe this case involves principles of major importance in guaranteeing minimally adequate care for handicapped citizens. Reversal of this case would strike a serious blow to the recognition of the rights of one class of handicapped citizens, the mentally retarded, at a time when enlightened opinion has begun to accept the fact that the denial of these rights is cruel and unnecessary.

SUMMARY OF ARGUMENT

The Developmentally Disabled Assistance and Bill of Rights Act, which is the focus of this appeal, must be considered in its context of massive federal legislation aimed at integrating handicapped persons into the mainstream of society. The legislation, which embodies a major national commitment to put an end to decades of isolation and neglect, was the product of years of Congressional investigations which made Congress keenly aware of the potential for growth and development of retarded persons

and the conditions under which this potential can be effectively nurtured.

In enacting this and related legislation, Congress unequivocally rejected the approach to retardation represented by institutions such as Pennhurst, embracing instead the principle of normalization which has been universally adopted by professionals in the field of mental retardation. To implement this principle, Congress mandated an end to the segregation of retarded persons in institutions such as Pennhurst which not only inhibit their development but actually cause them to regress. Congress, along with professionals and the courts, recognized that all retarded persons have some capacity for growth and that this capacity must be nurtured in the most normalized, least restrictive setting possible. Congress therefore enacted legislation to require states to modify the treatment of their retarded citizens in accordance with these principles by phasing out anachronistic institutions and replacing them with community residential facilities and community-based services.

Experience with normalized environments for retarded persons amply demonstrates the wisdom of this Congressional commitment. Throughout the nation, formerly institutionalized persons have shown remarkable progress in many areas of learning and behavior as a result of the community-based approach. Even severely and profoundly retarded persons are being successfully habilitated in community facilities, a fact which supports the District Court's finding that no resident of Pennhurst needs to be confined there. This finding remains unchallenged by the Commonwealth defendants.

Without denying the failure of institutions or the superiority of community services for retarded persons, petitioners nevertheless challenge the opinion below on the ground that the Third Circuit's construction of the Bill of Rights Act would unduly burden the states by imposing new funding obligations on them. This contention is totally specious. All the evidence, in the record and else-

where, makes it clear that community services cost substantially less than maintaining an institution such as Pennhurst. The federal statute as construed by the Third Circuit is consistent with Pennsylvania law, and the Pennsylvania Legislature has demonstrated its support of these policies by appropriating funds for the creation of community services. These funds remain largely unspent as a result of nothing more than administrative inertia.

When immediate and long-range economic benefits are added to the other compelling reasons in support of the decision below, it is hard to find any rational basis to oppose it. Accordingly, *Amici* respectfully urge this Court to affirm.

ARGUMENT

I. The Developmentally Disabled Assistance and Bill of Rights Act [1] Embodies a Major National Commitment to the Principles of Normalization and Deinstitutionalization, Based on Congressional Recognition That All Retarded Persons Are Capable of Growth and Development in an Appropriate Environment.

A. In Passing the Bill of Rights Act, Congress Explicitly Rejected the Anachronistic, Ineffectual and Inhumane Approach to Retardation Represented by Large Institutions Such as Pennhurst.

At the outset, *Amici* urge this Court to recognize that this case is more than an academic exercise in statutory construction.[2] On the contrary, it is a case that profoundly

1. 42 U. S. C. § 6010 *et seq.* (1975) (hereinafter cited as "the Bill of Rights Act").

2. Even if it were so conceived, the Bill of Rights Act can only be understood in its context of massive federal legislation and appropriations in the last decade designed to assist states in developing programs for handicapped citizens. *See, e.g.*, the Rehabilitation Act of 1973, 29 U. S. C. §§ 701 *et seq.*; the Education for All Handicapped

affects the lives of millions of human beings. Rhetoric aside, petitioners are asking this Court to do nothing more than condone the continued confinement of this nation's retarded citizens in institutions that deny them their basic human right to live and grow in the world. The Commonwealth has articulated no clear reason for perpetuating this cruel segregation of retarded persons, and, in the light of current knowledge about mental retardation, it is obvious that no good reason exists.

When viewed in its historical context, the segregation of mentally retarded persons, like racial segregation, emerges as a relic from the past, born out of ignorance and fear and serving no useful purpose. Institutions such as Pennhurst were first created early in this century at a time when the concept of mental retardation was quite different from what we know today.

Most of these institutions were little more than warehouses, providing mere custodial care at best and serving primarily to keep retarded persons out of sight.[3] This segregation was based on the beliefs that retarded persons were incapable of learning and development and that society needed to be protected from such deviant persons.[4]

2. (Cont'd.)

Children Act of 1975, 20 U. S. C. §§ 1401 *et seq.;* the Social Services Amendments of 1974, 42 U. S. C. §§ 1387 *et seq.*

The common theme of all this recent federal legislation for the handicapped, including mentally retarded persons, expresses a clear Congressional purpose to integrate these citizens into society and to provide them with equal opportunities to achieve their fullest potential for growth, development and independence. It is this clear Congressional purpose which *Amici* support and which petitioners ask this court to reject.

3. E. Gollay, R. Freedman, M. Wingaarden, N. Kurtz, *Coming Back, the Community Experiences of Deinstitutionalized Mentally Retarded People,* 9-10 (1978) (hereinafter cited as *Coming Back*).

4. C. Cherington, "Community Life and Individual Needs," *New Neighbors, the Retarded Citizen in Quest of a Home* 3-4

The cruel conditions to which retarded persons were subjected in these institutions were nothing short of a national disgrace. When Bengt Nirje, an international leader in the field of mental retardation, visited American institutions for the retarded in 1969, he described them as follows:[5]

> "They represent a self-defeating system with shockingly dehumanizing effects. Here, hunger for experience is left unstilled; here, poverty in the life conditions is sustained; here a cultural deprivation is created—with taxpayers' money, with the concurrence of the medical profession, by the decisions of the responsible political bodies of society."

Numerous scientific studies have confirmed Nirje's observations demonstrating that mentally retarded persons in large institutions suffer from apathy, stunted growth, and loss in I. Q., and that the level of behavioral functioning increases when persons are placed in smaller living units.[6]

In one major study of the effects of institutional experience on the behavior and development of retarded persons,[7] researchers found that institutionalized retarded children were severely deficient in their development of reliance on the internal resources that would determine

4. (Cont'd.)

(President's Committee on Mental Retardation, 1974) (hereinafter cited as *New Neighbors*).

5. B. Nirje, "A Scandinavian Visitor looks at U. S. Institutions," R. Kugel and W. Wolfensberger (eds.), *Changing Patterns in Residential Services for the Mentally Retarded,* 51, 56 (1969) (hereinafter cited as *Changing Patterns*).

6. Cited in **Halderman v. Pennhurst,** 446 F. Supp. 1295, 1311 (E. D. Pa. 1977), *aff'd* 612 F. 2d 84 (1979).

7. E. Zigler, D. Balla, "Impact of Institutional Experience on the Behavior and Development of Retarded Persons," 82 *Am. J. of Mental Deficiency* 1 (1977).

their ability to cope in the adult world. They also found that retarded individuals who maintained contact with parents or parent substitutes, either by being visited at the institution or by visiting at home, were more likely to display the type of autonomous behavior characteristic of non-retarded children. On the basis of these findings, the researchers concluded that frequent contacts with the community promote psychological growth while segregation from it inhibits such growth. Another finding which emerged from the same study was that living unit size was predictive of care practices. The most resident-oriented care practices were found in group homes rather than large institutions. The researchers concluded from this that one way of creating more humane settings for retarded persons would be to design living units small enough so that each person would be seen as an individual.[8]

These conclusions were echoed in the findings of the District Court in this case (446 F. Supp. at 1318):

> "minimally adequate habilitation cannot be provided in an institution such as Pennhurst . . . Pennhurst provides confinement and isolation, the antithesis of habilitation . . . Pennhurst has produced regression and in many instances has destroyed life skills possessed by its retarded residents at the time of their admission."

The Senate Report on the Bill of Rights Act acknowledges this litigation and makes it clear that Congress was intimately acquainted with the factual findings of these cases and intended to implement the holdings of these courts by the legislation it enacted. The Report stated:[9]

> "The inhumane and nonhabilitation aspects of these large institutions have unfortunately been graphically demonstrated over and over again. In a number of the crucial court cases, for example, the

8. *Id.* at 7.

9. S. Rep. No. 94-160, 94th Cong., 1st Sess. 546, 549 (1975).

> defendants were only too willing to stipulate that the conditions described by the plaintiffs were accurate. . . .
>
> The Committee is firmly convinced that Congress must take action to ensure the humane care, treatment, habilitation, and protection of mentally retarded and other persons with developmental disabilities . . .

It is obvious that Congress recognized the inadequacy of institutions for the retarded as well as the affirmative harm they inflict. It is also obvious that Congress recognized the failure of states to respond adequately to this problem and the necessity for despairing parents of retarded persons to resort to the courts for relief. Acknowledging the "scandals in a number of institutions"[10] and increasing litigation, Congress took action to eliminate this blight on our nation.

B. Congress Adopted the Principle of Appropriate Treatment in the Least Restrictive Environment in Recognition of the Abundant Evidence That This Approach Facilitates the Growth and Development of Retarded Persons.

The determination of Congress to phase out institutions for retarded persons was based not only on the recognition of their detrimental effects on the retarded persons trapped within them but also on the realization that there could be alternatives. In the last two decades it has become increasingly apparent that institutions for the retarded are *not* a necessary evil, a last resort for hopeless human beings, for it is now universally acknowledged that retarded persons are far from hopeless. As a result of increased public attention, the allocation of resources, and the discovery of new teaching techniques, it has been clearly established that every child, whatever his

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10. S. Rep. No. 94-160, *supra,* at 520.

handicap, can benefit from education [11] and that retarded persons of any age are capable of continued development with proper care and training.[12]

The increasing legal, philosophical, and political attacks on large-scale institutions have been based on the principle of normalization which has dominated the field of mental retardation in the past decade.[13] The principle of normalization has been defined as "making available to the mentally retarded patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society," [14] and is based on the tenet that a person responds according to the way he is treated. Thus, normalization is essentially a learning process through which a retarded person, like others not retarded, acquires language, personal, social, educational, vocational and recreational skills in order to achieve his maximum developmental potential.[15] Professionals in the field agree that for this purpose institutional care should be avoided in favor of community-based services.[16]

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11. T. Gilhool, "The Right to Community Services," *The Mentally Retarded Citizen and the Law,* 173, 179 (The President's Committee on Mental Retardation, 1976) (hereinafter cited as *Mentally Retarded Citizen*).

12. N. King, "Rights of the Mentally Retarded," 57 N. C. L. Rev. 336, 341 (1979). *See also* M. Minge and T. Ball, "Teaching of Self-Help Skills to Profoundly Retarded Patients," 71 *Am. J. of Mental Deficiency* 846-68 (1967).

13. B. Nirje, "The Normalization Principle and its Human Management Implications," R. Kugel and W. Wolfensberger (eds.), *Changing Patterns, supra,* at 179-195; *see also* G. Dybwad, *Challenges in Mental Retardation,* 83-98 (1964).

14. B. Nirje, *supra,* n. 16 at 181.

15. Mason and Menolascino, "The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal and Scientific Interface," 10 Creighton L. Rev. 124, 139-40 (1976).

16. W. Wolfensberger, *The Principle of Normalization in Human Services,* 28 (1972).

The capacity of mentally retarded persons for growth and development has also been increasingly recognized by the courts. In the first case to recognize the particular learning needs of mentally retarded children, **Pennsylvania Association for Retarded Citizens v. Pennsylvania**, 343 F. Supp. 279, 296 (E. D. Pa. 1972), the court stated:

> "[A]ll mentally retarded persons are capable of benefiting from a program of education and training; [the vast majority] are capable of achieving self-sufficiency and the remaining few, with such education and training, are capable of achieving some degree of self care; . . . the earlier such education and training begins, the more thoroughly and more efficiently a mentally retarded person will benefit from it and, whether begun early or not, . . . *a mentally retarded person can benefit at any point in his life and development from a program of education.*" (emphasis added)

See also **Mills v. Board of Education**, 384 F. Supp. 866 (D. D. C. 1972). Similarly, the District Court in this case found that "mental retardation is primarily an educational problem and not a disease . . . with proper habilitation, the level of functioning of every retarded person may be improved." 446 F. Supp. at 1298.

In enacting the Bill of Rights Act, Congress explicitly acknowledged and adopted the approach to mental retardation articulated by professionals and courts in the last decade. In its report, the Senate Subcommittee on the Handicapped adopted the view "that all developmentally disabled individuals have potential for learning and growth" and that:

> "Developmentally disabled persons should live like nondevelopmentally disabled persons to the greatest degree possible. Every effort should be made to assist developmentally disabled persons to maximize their ability for self-care and to live normal lives. From this, it also follows that each developmentally disabled

> person should be allowed to live in the least restrictive environment conducive to his or her maximum development." [17]

It is thus no accident that the language of the statute itself echoes the language of both the professional literature and the courts (42 U. S. C. § 6010(2)):

> "The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty."

Nothing could be clearer than that Congress intended to act on this knowledge and fully implement the judgment of professionals and the courts by making it the law of the land.

The benefits for retarded persons of integration into the community cannot be explained by statistics, for many of their achievements and satisfactions may not be measurable by ordinary methods. Anyone, however, who has experienced the feelings of pride and well-being that come with succeeding at a difficult task can understand the significance of mastering even a simple task for a retarded person who has previously been dependent on others for almost everything. It is, therefore, indefensible to deny the opportunity to learn to ride a bus, cook a meal and perhaps even hold a paying job to any person who, with proper assistance, has the capacity for these tasks.

In many cases, however, a retarded person's capacity for growth is not apparent in an institutional setting. Since retarded persons, like others, often behave the way they are treated, if they are treated as hopelessly dependent they are likely to remain that way. The District Court in this case noted a dramatic example of this principle, based on the testimony of the mother of Sid Auerbach, who was released from Pennhurst State School and

17. S. Rep. No. 94-160, *supra*, at 545.

Hospital to a community home. Mrs. Auerbach testified that her son had learned more in his three and a half years in the community than in his 38 years at Pennhurst. While at Pennhurst, he was subdued and never talked. Now, she testified, "you cannot stop him." In addition, he had learned to cook, work and keep his own bank account.[18]

This is a dramatic example of normalization at work. It is not, however, a unique example, as shown by a 1976 report of a nationwide descriptive study of community residential facilties.[19] Similarly, a study of the community living experiences of 400 deinstitutionalized retarded persons [20] revealed that their lives in many respects approximated those of ordinary people:

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18. 446 F. Supp. at 1311 n. 47.

Compare the story of Paul Nasielski, a 15 year old severely retarded boy who had been in Pennhurst for five years before his release to a community home in March, 1980. (J. Cass, "New Life for the Severely Retarded," *The Philadelphia Inquirer*, August 3, 1980 at 1A, col. 2) While at Pennhurst, Paul "refused to sleep. All night he would pace his darkened ward, or sit on his bed, ready to scratch, bite and kick anyone who came near. He did not like people near him during the day, either, and he often fell to the floor in a kicking, shrieking tantrum at Pennhurst's school." When he first left Pennhurst, "he would not sit still at the table to eat. He would not go out into the yard. He would not sleep. And he often scratched and kicked the staff members when they tried to lead him to the table or to his bed or to help him brush his teeth or get dressed." Within only a few months, however, the individualized attention he was receiving produced significant changes in Paul: "He is still hyperactive, but he sleeps most nights now and will let the staff touch him. He's learning to brush his teeth and dress himself. He goes outside on trips . . . [and, by mid-July,] Paul went home for dinner for the first time in almost 10 years."

19. G. O'Connor, *Home is a Good Place: A national perspective of community residential facilities for developmentally disabled persons* (1972) (Monograph of the American Association of Mental Deficiency, No. 2) (hereinafter cited as *Home is a Good Place*).

20. *Coming Back, supra.*

"Perhaps our most important finding was that mentally retarded persons are able to speak for themselves—accurately and poignantly. . . . In many ways, the experiences which they described were not unique—they did not differ from the kinds of experiences one would expect of 'normal' people in the community. Study group members spent time in their homes, went to work or school, watched TV, went shopping. Like most people, they were content with some aspects of their lives but dissatisfied with others. They encountered certain problems and tried hard to cope with them. Above all, these people were in the process of changing—adjusting to new homes and communities, acquiring new skills, making new friends, confronting new problems . . ." [21]

It is these kinds of experiences and activities, which most people so take for granted, that are denied the residents of Pennhurst and similar institutions. Their continued confinement thus deprives them of the most basic human right—the right to live and grow in the world. The expenditure of more money to "improve" these institutions would not diminish the deprivation. Only the opportunity to participate in the world, to the maximum extent their abilities will allow, would adequately fulfill the mandate embodied in the Bill of Rights Act and the underlying constitutional principles it reflects.

It is against this background that this Court should consider the opposition of a relatively small but very vocal group of parents to the deinstitutionalization of their retarded children. This parental resistance can best be understood in the context of the original decision to place these children in institutions. Such a decision necessarily involved much pain and anxiety as well as, for many parents, a tremendous sense of guilt and failure.[22] Having pain-

21. *Id.* at 158-59.

22. Carver, J. N., and Carver, N. E., *The Family of the Retarded Child* (1972).

fully resigned themselves to the necessity of such a step, these parents now must face a court-ordered reversal of their decision, fraught with the guilt-inducing implication that they have acted contrary to the best interest of their children. Moreover, having once persuaded themselves that only an institution, whatever its shortcomings, could provide their children with the care and protection they needed, they are threatened by the possibility that the institution will be closed and no adequate substitute will be provided. In short, "deinstitutionalization . . . involves a painful reversal and revisitation of this original decision and has the potential to serve as a major crisis for the family . . ." [23]

Such feelings on the part of parents are understandable and ought to be taken seriously. They should not, however, be permitted to obscure the fact that, no matter how inevitable or even desirable institutionalization once appeared, it is now virtually undisputed among professionals that it is both harmful and unnecessary. Parental fears that their children, once removed from the predictable environment of a Pennhurst, will simply be "dumped' on the community and abandoned are not borne out by actual experience with deinstitutionalization throughout the nation, nor is such a result permitted under the order of the District Court in this case.

Moreover, parents who have seen the changes in their retarded children as a result of living in a more normalized environment have thankfully abandoned their opposition. Research on the effect of deinstitutionalization on the families of retarded persons has concluded that, although

23. B. Willer, J. Intagliata, and A. Atkinson, "Deinstitutionalization as a Crisis Event for Families of Mentally Retarded Persons," at 3 (1975). (Unpublished report of study assisted under Department of Health, Education, and Welfare, Region II, Office of Human Development, Developmental Disabilities Office, Grant N. 50P10568/2.) *See also,* R. Frohboese and B. Sales, "Parental Opposition to Deinstitutionalization: A Challenge in Need of Attention and Resolution," 4 *Law and Human Behavior* 1 (1980).

many families experienced crisis at the time of discharge, two years later almost all indicated that they no longer disagreed with the discharge decision, and the majority were adamantly opposed to a return to the institution.[24] Thus, while there is clearly a need for understanding and suuport of parents undergoing crisis, it would be a serious mistake to allow parental resistance to change to determine the outcome of this case.

C. Deinstitutionalization of Mentally Retarded Persons and Their Integration Into the Community Are Practical, Achievable, and Necessary Goals.

The goal of normalization in a community setting is not an abstract philosophical concept or, as petitioners would have this Court believe, a utopian legislative ideal. It is an idea whose time has come and an idea that works. The past decade has witnessed a mass movement of mentally retarded citizens out of institutions and into communities and the results have shown not only that it can be done but also that, for many reasons, it *ought* to be done.

Follow-up studies of community placements necessitated by **Wyatt v. Stickney**, 344 F. Supp. 387 (M. D. Ala. 1972), aff'd in part, remanded in part and decision reserved

24. Willer, et al., *supra* n. 23, at 16. Compare the reaction of Joan Nasielski, mother of Paul Nasielski, whose progress following release from Pennhurst is described in note 18, *supra*. Following Judge Broderick's order, Mrs. Nasielski was so upset that she, along with a number of other parents, sent a letter to the judge saying they did not want their children taken from Pennhurst and "dumped" into the community. However, when Mrs. Nasielski actually examined a community facility which was the home of a boy much like Paul, she became enthusiastic. Only a few months later, after Paul's first visit home, she was "exuberant" over the changes in him. She poignantly commented, "When I put Paul in an institution, I felt like I gave up on him. Now I think, 'What's he going to be like in 10 years?'" *The Philadelphia Inquirer,* August 3, 1980, at 15A.

in part sub nom. **Wyatt v. Aderholt**, 503 F. 2d 1305 (5th Cir. 1978), and **New York State Association for Retarded Citizens v. Carey**, 393 F. Supp. 715 (E. D. N. Y. 1975) (the "Willowbrook case"), confirm that such placements can be successful and that deinstitutionalization is a realistic remedy, even though the need for community facilities far outstripped availability when the orders were issued.[25] In the first year after the order in **Wyatt**, 500 residents were released from Partlow State School and Hospital, bringing the population down to 1,745. Further reductions were planned to bring the population down to 700. During that same year the number of qualified staff doubled, and the Department of Mental Health began to develop a range of community services for retarded persons.[26]

Similarly, the Willowbrook order required the reduction of the resident population from more than 5,000 to 250 by May, 1981. The implementation of this order has demonstrated that even profoundly retarded persons can be placed successfully in the community.[27] Between May, 1976, and October, 1978, approximately 800 community placements had been accomplished and all have been verified as valid. Of these, 58% were diagnosed as severely or profoundly retarded, yet they are functioning successfully in apartments or group-living arrangements.[28]

Other experiences with deinstitutionalization confirm the Wyatt-Willowbrook results.[29] Bronx Developmental

25. *"Wyatt,* Willowbrook Studies Evaluate Success of Community Placement," 2 *Mental Disability Law Reporter,* 422-23 (1978) (hereinafter cited as *"Wyatt,* Willowbrook Studies").

26. C. Halpern, "The Right to Habilitation," *Mentally Retarded Citizen, supra,* at 385, 401.

27. *"Wyatt,* Willowbrook Studies," *supra.*

28. Plan for Placements, p. 8, prepared by N. Y. City Long Island County Service Group Office (December 1, 1978).

29. *See generally, Coming Back, supra,* a study of the experiences of over 400 mentally retarded persons returned to communities from institutions; B. Baker, G. Seltzer, M. Seltzer, *As Close as*

Services, a program started in 1975, successfully placed 36 retarded persons in independent living arrangements. The residents, ranging from mild to profound retardation, were placed in apartments, using federal funding mechanisms already established to provide needed services within the community.[30]

The Eastern Nebraska Community Office of Retardation (ENCOR) has been developing a community service system as an alternative to institutional care since 1969 pursuant to statute.[31] In 1968 the only alternatives in Nebraska for retarded persons were living at home or living in an institution. The only public institution was, like Pennhurst, remote, understaffed, and therapeutically inadequate. It housed 2,300 residents. By 1973 fewer than 1,200 residents remained, and the waiting list had been eliminated. Local services of a high quality provided a comprehensive continuum of services so that institutional residents were able to be returned to their home communities.[32]

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29. (Cont'd.)

Possible, Community Residences for Retarded Adults (1977), a survey of community residences across the country, including on-site examinations of 17 programs, among which are group homes, foster family care, workshop-dormitories, and semi-independent apartments; *Home is a Good Place, supra,* a nationwide survey of community residential facilities. *See also,* L. Glenn, "The Least Restrictive Alternative in Residential Care and the Principle of Normalization," *Mentally Retarded Citizen, supra,* at 499, 507-12, for a description of alternative types of community living arrangements (hereinafter cited as "Least Restrictive Alternative in Residential Care").

30. "Living Arrangements for People with Life Long Disabilities," Temple University Sugarloaf Conference Center, 6-7 (February 13-17, 1977).

31. Neb. Rev. Stat. 83-1, 141 (1967).

32. "Least Restrictive Alternative in Residential Care," *supra,* at 512-14. B. Lensink, "One Service System at Work," *New Neighbors, supra,* at 105.

All of these experiences demonstrate that the removal of mentally retarded persons from segregated institutions and their integration into the community are achievable goals. Moreover, similar results have been achieved in Pennsylvania to the extent that the District Court's order has been implemented. The local newspapers have chronicled the success of community programs for former Pennhurst residents who have been fortunate enough to be released, and one can see many of these once hopeless people riding the buses to work and shopping in supermarkets. The Commonwealth defendants have never denied these successes,[33] nor have they denied that persons remaining in Pennhurst also ought to be placed in the community. Nevertheless, it comes before this Court to assert its right to deny those benefits in favor of continued confinement.

Since the benefits of community placement are as undeniable and undisputed as the detrimental effects of institutionalization, the only rational course is to follow the congressional mandate embodied in the Bill of Rights Act. Petitioners have offered no valid reasons for their reluctance to do so. In the absence of such reasons, the goals of deinstitutionalization and normalization must be pursued on the basis of practical and humane considerations as well as legal imperatives.

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33. This success is demonstrated by plaintiffs' analysis of the trial record, comparing residents in various units of Pennhurst with comparably handicapped citizens in a community program. This analysis, attached to the Brief as Appendix A, is a cross-index of the trial record. An attached article describes the community program in which some of the retarded persons were placed. In other instances, the program is described in the record. This analysis supports plaintiffs' contention that for every resident of Pennhurst, there is a twin, a person similarly handicapped, being successfully treated in the community.

II. Since Community Services Cost Less Than Institutional Care, Compliance With the Bill of Rights Act, as Construed by the Court of Appeals, Does Not Impose New Funding Obligations on the States, as Petitioners Allege.

Petitioners purportedly object to the decision of the Court of Appeals on the ground that its construction of the Bill of Rights Act imposes a "massive obligation on the States" to fund newly created federal rights which "do not simply limit state action, but require the provision of services." (Petitioners' Brief, pp. 12-13). In taking this position, petitioners totally misrepresent the issues in this case and ignore the facts in the record. It is undisputed that conditions at Pennhurst are abominable, that residents generally regress in institutions, and that community services provide a more humane and more effective approach to mental retardation. The state does not challenge these conclusions but argues that it nevertheless may choose to confine retarded persons in Pennhurst for economic reasons. Aside from the constitutional implications of such an argument,[34] it is disingenuous at best, for it implies that states would be unduly burdened if coerced into providing humane alternatives to the mass incarceration of their retarded citizens. Such a conclusion has no basis in fact.

Contrary to petitioners' assertions, the Bill of Rights Act does not carve out a new area for the provision of services by the states. Rather, it requires states to modify the services they are *already* providing to retarded citizens in order to make them both effective and humane. In that

34. The Supreme Court has consistently held that due process may not be denied nor fundamental rights infringed merely for the sake of financial considerations. **Memorial Hospital v. Maricopa County,** 415 U. S. 250, 263 (1974); **Goldberg v. Kelly,** 397 U. S. 254, 266 (1969); **Shapiro v. Thompson,** 394 U. S. 618, 633 (1969). *Cf.* **Jackson v. Bishop,** 404 F. 2d 571, 580 (8th Cir. 1968): "Humane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations . . ."

sense, it does limit state action by prohibiting continued expenditure of state funds to inflict harm upon retarded citizens,[35] and requiring that the services provided by the state be reasonably related to habilitation.[36] There is no evidence, in the record or anywhere else, that compliance with these requirements will impose massive funding obligations on the states.

A. The Record Is Clear That Confinement of Retarded Persons at Pennhurst Costs Substantially More Than Their Placement in the Community.

Concededly, petitioners' concern with a Congressional imposition of new funding obligations upon the states might raise serious legal issues if considered in a vacuum. These issues, however, are totally irrelevant to the factual record of this case. The District Court's factual findings included the following cost data (446 F. Supp. at 1312):

> "Comparable facilities in the community are generally less expensive than large isolated state institutions. Services can be purchased at regular rates, rather than at rates which must be paid to attract individuals to work in a setting like Pennhurst. The cost of running Pennhurst in 1976 was $27.8 million dollars, or $60 per resident per day. This does not include the fair rental value of the buildings at Penn-

35. It is important to note that the statute, 42 U. S. C. § 6010 (3), does not merely limit the uses of federal funds provided under it but clearly prohibits the use of *public* funds, *i.e.*, state as well as federal, in ways that violate the statutory mandate.

36. The Act as construed by the Court of Appeals is thus well within the power of Congress under Section 5 of the 14th Amendment and is clearly distinguishable from **Harris v. McRae,** 48 U. S. L. W. 4941, 4947 (June 30, 1980), on which petitioners rely. The Court of Appeals specifically noted that "Section 6010 does not go beyond what has been judicially declared to be the limits of the 14th Amendment but clearly is within those bounds." **Halderman v. Pennhurst,** 612 F. 2d 84, 98 (1979).

> hurst (estimated at $3-to-$4 per resident per day). The statewide cost of community living arrangements in Pennsylvania for 1976 was $17.64 per individual per day. Program services, which ⅓ of mentally retarded individuals would need, average approximately $10 per individual per day." (Citations omitted)

In light of this undisputed evidence that *community services on the average cost less than half* the cost of maintaining residents at Pennhurst, the Commonwealth's resistance to complying with the Bill of Rights Act on economic grounds is totally irrational.

The speciousness of the Commonwealth's fiscal concerns is further underlined by the District Court's finding that additional funds had been appropriated by the Pennsylvania Legislature specifically for the provision of community facilities for retarded persons and that the Commonwealth and its subdivisions had simply failed to make use of these resources. Of $21 million dollars appropriated in 1970 for the purpose of planning, designing and constructing community facilities to enable 900 Pennhurst residents to be transferred to the community, over $18 million dollars remained unspent at the time of trial. 446 F. Supp. at 1312.

A similar finding was made by a Pennsylvania juvenile court which ordered Philadelphia County to provide two mentally disabled juveniles with community-based treatment consistent with their individual needs. **In the Matter of Stefanie L.**, J. No. 184929 (Pa. C. P. Phila. County, Juv. Div. June 30, 1977).[37] The court heard evidence that despite state funding for community living arrangements for the mentally disabled, Philadelphia County had neither an appropriate facility to meet the needs of these juveniles, nor a proposal to establish facilities to meet the needs of the sizable class of persons similarly situated. Instead, over a million dollars designated for com-

37. Reported in 2 *Mental Disability Law Reporter* 364 (1978).

munity living arrangements had been returned by Philadelphia County to the Commonwealth! Concluding that these children were entitled to meaningful care appropriate to their individualized needs in accordance with Pennsylvania law,[38] the court ordered the creation of a suitable program.

It is obvious, therefore, that the posture assumed by Pennsylvania for the purpose of this appeal has nothing to do with reality. Neither a shortage of funds nor a difference in philosophy is involved in the Commonwealth's reluctance to comply with the District Court's order. Indeed, Pennsylvania law is consistent with the federal requirement of appropriate individualized services, and the Pennsylvania Legislature has expressed its agreement with the mandate of Congress by specifically allocating funds for the creation of community facilities.

Moreover, the District Court found that "[a]ll the parties in this litigation are in agreement that given appropriate community facilities, all the residents at Pennhurst, even the most profoundly retarded with multiple handicaps, should be living in the community." 446 F. Supp. at 1312. The Court further found that "[t]he primary limiting factor in the transfer of Pennhurst residents to community facilities has been the failure of the Commonwealth and its subdivisions to provide sufficient living units, vocational and day-care facilities and other support services at the community level." *Id.* In short, in spite of "complete agreement that the residents of Pennhurst should be transferred as soon as practicable to appropriate community facilities, apparently no one has taken the initiative to accomplish this objective." *Id.* at 1313.

Thus, reduced to its simplest terms, petitioners' argument has nothing to do with the fiscal integrity of the state or the related concept of federalism. On the con-

38. Juvenile Act of 1972, 11 P. S. § 50-101 *et seq.*, and the Pennsylvania Mental Health and Mental Retardation Act of 1966, 50 P. S. § 4101 *et seq.*

trary, having already appropriated the funds and adopted the principles embodied in the federal Act, the Commonwealth now seeks to spend *available money* in total disregard of those principles, as a perverse demonstration of its sovereign power to do what it chooses, however arbitrary and capricious its conduct may be.

In this context, it is significant that the Commonwealth itself has offered not a single reason for its unwillingness to comply with the District Court's order and the Bill of Rights aside from the totally specious issue of scarce economic resources. The conclusion is unavoidable that the state is doing nothing more than asking this Court to uphold bureaucratic apathy and inertia at the expense of human rights.

B. Experience Throughout the Nation Confirms That Community Services for Retarded Persons Are Cheaper to Provide Than Institutional Care.

The economic data in Pennsylvania is not aberrational. On the contrary, available evidence from the many states which, pursuant to court order [39] or state statute,[40]

39. *See, e.g.,* **Wyatt v. Stickney,** *supra;* **New York State Association for Retarded Citizens v. Carey,** *supra;* **Evans v. Washington,** 459 F. Supp. 483 (D. D. C. 1978). The institutions affected by these deinstitutionalization orders were Partlow State School and Hospital in Alabama, Willowbrook Developmental Center in New York, and Forest Haven in Washington, D. C.

40. Under the influence of the normalization principle and abundant federal legislation, an increasing number of enlightened state legislatures have enacted new laws to improve the treatment of mentally retarded persons and accelerate their integration into the community. *See, e.g.,* Neb. Rev. Stat. 83-1, 141 (1967); Tenn. Code Ann. §§ 33-1601 (1971); Mont. Rev. Codes Ann. §§ 38-1201, *et seq.* (1975); F. S. A. § 393.13 (Fla. 1977); West Ann. Welf. and Inst. Code §§ 4500, *et seq.* (Cal. 1977); Ohio Rev. Code Ann. § 5119.801 (1977); 43-1-8, 43-1-9, NMSA (New Mexico 1978);

have embarked on major deinstitutionalization programs consistently demonstrates that community services are substantially cheaper to provide.

An analysis of the average cost of care of 362 persons transferred pursuant to court order from the Willowbrook Developmental Center in New York into small placement centers in other communities indicated an average saving of at least 50 percent. According to the study, the average cost of care of retarded persons transferred to community settings was $13,208 per year as compared to costs of from $25,000 to $32,000 a year in state institutions for the mentally retarded.[41] Even more favorable cost data was reported two years later when the average annual cost of institutionalization was estimated at approximately $30,000 per person as compared to between $9,000 and $12,000 per person for group home maintenance.[42]

The state of Nebraska has also recognized significant cost reduction by changing from institutional to community care, and the high quality of its comprehensive program has served as a model for the entire nation.[43] As of 1977, the average daily cost per client was $31 with a range from $8

40. (Cont'd.)

V. A. M. S. § 202.193 (Missouri 1978). Many of these statutes explicitly require appropriate habilitation in the least restrictive environment.

41. Costs of Services for Willowbrook Class Clients in Community Placement, Metropolitan Placement Unit (New York State Department of Mental Hygiene, September, 1977).

42. Testimony of Kathy Schwaninger, Executive Director of the Willowbrook Review Panel, December 7, 1979, cited by the Court in **New York State Association for Retarded Children, Inc. v. Carey,** No. 72 Civ. 356/357. Slip op. (E. D. N. Y. January 2, 1980 and April 10, 1980).

43. "Least Restrictive Alternative in Residential Care," *supra,* at 512-14.

to $54, depending on the services needed.[44] More recent figures for Nebraska were reported by Jerome Griepentrog, testifying for defendants in **Kentucky Association of Retarded Citizens v. Conn**, Civil No. C78-0157L (A) (W. D. Ky., filed March 21, 1980): the average cost is $9,000 per client in the community compared to up to $20,000 per client in the institution.[45] Testimony in the same case revealed that in Montana the cost is just under $11,000 per client in the community as compared to over $28,000 per institutionalized client.[46]

Amicus United Cerebral Palsy Associations (UCPA) has itself sponsored projects to provide community living arrangements for severely disabled adults who had been previously institutionalized. These services have been provided at substantially less than the cost of institutional care. UCPA of Pittsburgh, for example, successfully placed 33 severely disabled adults in community-based living arrangements at a cost of approximately $27 per day per person. The cost for these same clients in an institution or intermediate care facility was approximately $75 per day.[47]

Since there is overwhelming evidence, both in the record and in the professional literature, that institutionalized mentally retarded persons tend to regress, and since experience throughout the nation has shown that these same persons can be helped to function effectively in communities, a decision that allows Pennsylvania and other states to perpetuate institutions such as Pennhurst out of sheer inertia would be tantamount to a decision to buy inferior services at a higher price. Such a decision is waste-

44. "Living Arrangements for People With Life Long Disabilities," Temple University Sugarloaf Conference Center, 10-11 (February 13-17, 1977).

45. Griepentrog Tr. 54, 225.

46. Hamerlynck Tr. 2033-34.

47. "Living Arrangements for People With Life Long Disabilities," *supra*, n. 44, at 9.

ful not only of public funds and resources but, even more important, of human lives and human potential.

C. By Maximizing Developmental Potential and Increasing the Independence and Productivity of Retarded Persons, Deinstitutionalization Provides Long-Term Economic Benefits for Both the States and the Nation.

In addition to the immediate cost reductions resulting from habilitation of mentally retarded persons through community services, substantial long-run economic benefits will result from the achievement of growing self-sufficiency and productive employment. It has been estimated that each handicapped child who receives an appropriate education is worth at least a quarter of a million dollars to society; half in reduced welfare and institutional costs and half in increased productivity.[48] Among every 30 retarded children, 29 have the potential to achieve self-sufficiency with the proper program: 25 in the ordinary market place and 4 in a sheltered environment. The remaining one, with proper training, can achieve a significant degree of self-care.[49]

Factual findings made by the District Court in this case reached a similar conclusion (446 F. Supp. at 1312):

> "[K]eeping the retarded individual in the community makes it possible for him or her to get employment. Eighty-five percent of the mentally retarded can be employed, though not all are capable of competitive employment. The lifetime earnings of a mildly retarded individual often exceeds $500,000. For those

48. "Handicapped Children's Education Project, A Summary of Issues and State Legislation Related to the Education of Handicapped Children in 1972," 1 Report No. 36 of the Education Commission of the States (1973).

49. T. Gilhool, "The Right to Community Services, *Mentally Retarded Citizen* 173, 179-80.

with an IQ between 25 and 50, 45% of men and 12% of women earn about 20% of the average wage. When the retarded can work, the amount of financial support which society must provide decreases and the individuals may benefit society with the taxes they pay. Furthermore, the investment per individual at Pennhurst is primarily for warehousing and not for the individual's well-being or future planning, as is the case with community facilities." (Citations omitted)

Congress itself has acted on the belief that "[r]ecognition of the needs and rights of the mentally retarded and the research engendered by this recognition will ultimately result in great reduction in the hundreds of millions of dollars expended annually in this country on welfare and maintenance services." [50]

Aside from the economic benefits resulting from lower welfare costs and higher productivity, providing appropriate community-based habilitation for retarded citizens produces the intangible yet immeasurable benefits of increased independence. The emphasis on independence and self-sufficiency in federal legislation for the handicapped [51] reflects the high value that Congress and the nation have traditionally placed on these goals.

Obviously, no one can learn to function in a community while being totally isolated from it. Retarded persons, however, who have been placed in community settings have the maximum opportunity to learn and develop the kinds of behavior that may enable them to participate in the life of the community. It is to this end that *Amici* ask this Court to affirm the decision of the courts below.

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50. 1970 U. S. Code Cong. and Adm. News 4717.

51. *See, e.g.*, 42 U. S. C. § 1396, 42 U. S. C. § 1397, 29 U. S. C. § 701.

CONCLUSION

As friends of the Court, the National Association for Retarded Citizens, the United Celebral Palsy Associations, Inc., and the Epilepsy Foundation of America support the order of the court below as a necessary step forward in the protection of the rights of the retarded. Its order should be affirmed.

Respectfully submitted,

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Special thanks from counsel are due to Joyce S. Meyers, a recent graduate of the University of Pennsylvania Law School, who wrote the first draft of this brief and whose work is largely reflected in its final form.

APPENDIX A

COMPARISON OF PENNHURST RESIDENTS WITH "TWINS" IN COMMUNITY

PENNHURST			COMMUNITY EQUIVALENT	
Transcript (Expert)	Exhibit 2 Description	Expert Description	Community Facility	Transcript (Expert)
2-43 (Clements)	C-13 Boys, m/s, some agression, some need further tr. self-help	Employee observing 2 boys in shower/no privacy bath or toilet.	Ken Crest - 6224 Wissahickon/Keystone Learning Ctr. - Boothwyn	6-49,52,55,59 (Glenn) 5-139,154,156 (Girardeau)
1-121,122 (Roos)	M-3 Boys, m/s some agression, need further self-help	Sitting around, lying on floor, only 1 shower Taken econ. aband. 2 yrs. ago, no substitute. Seclusion room.	Rivercrest Center Montclare Ken Crest - 431 Sentner St.Phila.	25-11,12,13,14, 15, 26-3,4 (Bilyew Testimony)
2-47 (Clements)	Unit VI K-2 men, Prof., need tr. self-help, no phys. problems	Open space, many beds no privacy	INTERAC - Shawmont Apts.	6-49,56 (Glenn)

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Transcript (Expert)	Exhibit 2 Description	Expert Description	Community Facility	Transcript (Expert)
		bathed in same tub; 5 res. & 2 staff in bathing area/no program; wheel chairs not attaptive/ crib type beds, too close to get between; no privacy/25% on tranquilizers.		
6-142, 148 (Settle)	Unit V D-1 Boys and Girls mod/p - non-amb.	Depressing, poorly lighted, poor positioning	Lynch Home, Willow Grove	5-139,144,145 147 (Girardeau)
2-76 (Clements) 5-93 (Girardeau) 4-184 (Sprague)	D-3 Boys, s/p, min. skills; some limited. amb.	Child digging material off floor, no superv. Beds crowded, no sheets, bare environ., seclusion room	Community Interaction - 2923 Garret Rd. Drexel Hill, Pa.	5-152,153 (Girardeau)

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PENNHURST			COMMUNITY EQUIVALENT	
Transcript (Expert)	Exhibit 2 Description	Expert Description	Community Facility	Transcript (Expert)
1-113 (Roos)	Unit I Mod. men & women mod/sev.	small living unit 15 res.	INTERAC - 300 Parker Avenue CARC - West Chester Apts. EMAN - 153 E. Mt. Airy Ave.	6-49,52,55 (Glenn) 5-140,156 (Girardeau) 6-50,52 (Glenn)
2-32,89 (Clements)	Unit II C-10 young men, over 21 m/s	severely retarded; ICF; Staffing - 1st shift 1:30, 2nd shift 1:61, 3rd shift 1:20; 50% on tranquilizers	Elwyn - 3900 Chestnut Street EMAN - 729 Vernon Rd. (Coed)	6-49,53 (Glenn) 6-49 (Glenn)
2-32 (Clements)	Unit III K-1 men. phys. hdcp. m/s, wheel chair	staffing - 1st Sh. 1:24, 2nd Sh. 1:16, 3rd Sh. 1:24	UCPA - Apts.-Pgh.	Described in Weinrich, Appendix B pp. 7-9
1-121, 134 (Roos)	Unit IV C-9 women, non-amb multi-hdcp.	Individual tied in bed. Many sitting about - wheel ch. - no organized activity/2 women being (Cont'd next page)	Cliff View Manor	Described in attached statement

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PENNHURST			COMMUNITY EQUIVALENT	
Transcript (Expert)	Exhibit 2 Description	Expert Description	Community Facility	Transcript (Expert)
1-124,133,135 (Roos)	H-2 women, prof., need tr. self-help, some abusive, some amb. prob.	Lack of daily prog. scheduled or individual objectives; seclusion, restraint, heavy med., leather muffs.	500 N. Franklin St. Pottstown , Pa.	6-49,55,56 (Glenn)
2-89 (Clements)	Unit VII C-7 men, limited self-help, prof.	65% on tranquilizers	Cliff View Manor	Described in Weinrich, Appendix B, pp. 7-9
2-33,43 (Clements)	C-8 women, limited self-help/behav. prob., prof.	Prof., difficult behaviors; ICF; 36 res. Staffing - 1st Sh. 1:12; 2nd Sh. 1:12; 3rd Sh. 1:18; Congregate bathing, no prov.	New Challenges 660 Burmont, Drexel Hill Bronx Developmental Services	6-176 (Settle) Described in Weinrich, supra., at 6-7

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PENNHURST			COMMUNITY EQUIVALENT	
Transcript (Expert)	Exhibit 2 Description	Expert Description	Community Facility	Transcript (Expert)
1-130, 132, 131, 133, 134 (Roos)	Unit VII Q-1 men, M/p, sev. mal. behav., short term treatment.	Leather hand restraint; token econ. abandoned/ inability to get reinforces; Day room bare; bed close together, lg. bedroom; seclusion rm., locked ward; little turn over, res. stay for yrs.	Macomb-Oakland Cntr. Mt. Clemens, Michigan	6-60 "Same continuium will work with more sever. handicapped persons." All providers willing to expand service. (Glenn)
2-51 (Clements)	Q-2 women, M/p, sev. mal. behav., short term treat.	Many in bed close together, individual restrained.	ENCOR Program Omaha, Nebraska	6-36 to 46 (Glenn)
1-120 (Roos) 2-54, 58 (Clements)	New Horizon Bldg. Unit IX 47 women, phys. prob.	Open bedroom area, hard surface, low divider sep. area, 2 beds, no auditory privacy; aimless wandering, no staff present in day room 2:40 P.M.	Univ. of Oregon Demonstration Programs.	Described in Bellamy Community Living For Severely and Profoundly Retarded Adults: A Group Home Study, Attached.

APPENDIX A

COMPARISON OF PENNHURST RESIDENTS WITH "TWINS" IN COMMUNITY

PENNHURST			COMMUNITY EQUIVALENT	
Transcript (Expert)	Exhibit 2 Description	Expert Description	Community Facility	Transcript (Expert)
1-122, 125 (Roos)	48 men, phys. prob. nursing, prof., age 35+	No interaction staff & residents; Lg. group aimlessly milling; lack of systematic prog. bare rooms	University of Oregon Demonstration Programs	Described in Bellamy, supra.
2-77 (Clements)	52 young men, abusive, nurs.	2 young men lying on floor/no activity, mid. day	Newgate Education & Residential Center; 2010 Minnehaha Minneapolis, Minn. 55404	(Jones, Admin.)
1-120, 121 (Roos)	49 men, age 35+/phys. prob., need nurs.	large group lying on floor or sitting around.	UCPA of New York State	Described in Weinrich, supra. at 9-10; 12-13

UNITED CEREBRAL PALSY ASSOCIATION OF THE PITTSBURGH DISTRICT

House Building, Four Smithfield Street
Pittsburgh, PA 15222 261-5831

SUPERVISED APARTMENT PROGRAMS FOR PHYSICALLY DISABLED ADULTS

United Cerebral Palsy Association of the Pittsburgh District has been active in the area of housing for the physically handicapped since early 1974. Although our efforts have included housing advocacy and community education, our most comprehensive service is our Supervised Apartment Projects.

Presently, United Cerebral Palsy coordinates three separate projects funded by the Community Living Arrangement Program of the Pennsylvania Department of Public Welfare through the Allegheny County Mental Health/Mental Retardation Program. Since each program has its distinct features, they will be discussed separately.

CLIFF VIEW MANOR

In November 1975, UCP opened its first supervised apartment project at Westgate Village in the southwest section of Pittsburgh. However, due to limited options for program at this site, the project was moved to Cliff View Manor Apartments located near North Versailles in Allegheny County where this HUD funded construction was completed in August 1978.

Cliff View Manor is composed of 48 garden type apartment arrangements designed to serve low income and elderly families. With four 3-bedroom apartments available to UCP on the first floor of one building, this new setting offers excellent accessibility and programmatic options.

Presently, 9 disabled residents (3 per apartment) make their home at Cliff View Manor. All residents have separate lease agreements with the management and due to their limited Supplemental Security Incomes (SSI), the rent fee is on a sliding scale based on 25% of each resident's income under the Housing and Urban Development Section 8 Rent Subsidy Program.

All the apartments have been adapted with assistive devices (grab bars, tub lifts, ramps, etc.) and are totally accessible to the disabled residents. Presently, 5 of the 9 residents at Cliff View are non-ambulatory.

Agency staff are supervised through a live-in Resident Advisor who has an apartment at Cliff View, which is close to, but separate from the 3 resident apartments. This staff apartment is rented by United Cerebral Palsy and serves as an office headquarters for the non-resident Counselor/Advisor.

The staff Counselor/Advisors provide assistance and support to the disabled residents on a scheduled basis. Since all the residents are involved in some type of day program or work activity center, the staffing patterns are heaviest in the evening and on weekends.

Cliff View, as well as other apartment projects to be discussed, each has an adapted van with an electric wheelchair lift that provides all necessary transportation services for the residents.

VILLAGE ON THE GREEN

With the success of our present Cliff View program, UCP received funds through MH/MR in March 1977 to develop a second apartment project to serve the physically handicapped, developmentally disabled adult. This program is located within the Village on the Green Townhouse Apartment complex in the South Hills area of Allegheny County.

Although similar in design to Cliff View, Village on the Green are privately owned apartments. With this in

mind, UCP negotiated with the Allegheny County Housing Authority for rent subsidization which was granted under the Housing and Urban Development Section 8 Housing Assistance Payment Program. Once again, the residents sign their own lease with the County Housing Authority and pay rent and utilities calculated on one-fourth of the residents' monthly Supplemental Security Income check.

Village on the Green also serves 9 residents (ambulatory and non-ambulatory) with the same supports offered at Cliff View (staff apartment, apartment adaptions and devices, specialized vans and program scheduled staffing pattern).

CEDAR RIDGE MANOR

As UCP's housing experience intensified, in March 1978 the opportunity to develop and implement a trail-blazing apartment program to reach the very severely involved adult who has attendant care needs was realized. This population, who for the most part have been institutionalized, constitute the residents of our third apartment project located at Cedar Ridge Manor Hi Rise in the Monroeville section of Allegheny County.

At Cedar Ridge there are 3 residents who are wheelchair-bound and require direct assistance in all areas of their Activities of Daily Living (ADL) such as dressing, feeding, bathing and toileting; 3 adults who are confined to wheelchairs, but who are able to provide for their own personal care; and 3 residents who have motor deficits but who are ambulatory. One person representing each degree of disability resides in a three-bedroom apartment that is individually leased to the residents under the Allegheny County Housing Authority's Section 8 Rental Subsidy Program. The adapted apartments and wheelchair van are program funded by MH/MR as in the other programs, however, more sophisticated assistive devices are available because of the severity of the residents.

Those include Hoyer lifts, electric wheelchairs, telephone dialing services, etc.

Since there are more intense "hands-on" needs for the residents, the staffing pattern is doubled at the Cedar Ridge program. Along with the direction, support and advice offered (again as in the other programs) the Cedar Ridge staff are also prepared to provide direct attendant care needs such as bathing, dressing, toileting, meal preparation, etc.

GENERAL ISSUES

Each disabled person considered for these Community Living Arrangement programs must be deemed appropriate (eligible) to obtain service through the Allegheny County MH/MR Program. The resident must be 18 years of age or older and have a motor disability. Except for the three special direct attendant care slots, the resident needs to have the skills for the Activities of Daily Living, or have the potential to learn these skills with program training. All residents are selected with an attempt to balance between persons coming from the local community and the remainder from state funded institutions for the mentally retarded. There are also an equal number of individuals in wheelchairs and those who are partially ambulatory which includes those using mobility aids such as canes and crutches.

All residents must be referred through their home MH/MR Base Service Units (BSU). Each BSU in Allegheny County is aware of UCP's Community Living Arrangements Programs and makes appropriate referrals to UCP.

An Admissions Utilization Review Committee (AURC) meeting is arranged to review all referrals and is comprised of UCP's Residential Program Director, Allegheny County MH/MR officials and the Base Service Unit representative. If deemed appropriate, the referred person is put on a waiting list (if an immediate opening does not

exist) and all program planning is centralized by UCP with the BSU assistance.

Prior to the AURC meeting all necessary records including medical, social, psychological and other identifying information are gathered by the BSU and these constitute the initial Individual Program Plan for the client.

United Cerebral Palsy Association of Pittsburgh is keenly aware of the part we have to play in meeting the housing needs of the disabled. All of our programs, including our housing efforts, are founded upon the principles of normalization and equal rights.

We would be happy to answer any specific questions you may have by calling our headquarters at 261-5831.

jc
8/8/78

Supreme Court, U.S.
FILED
OCT 29 1980
MICHAEL RODAK, JR., CLERK

Nos. 79-1404, 79-1408, 79-1415, and 79-1489

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

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Petitioners,

v.

TERRI LEE HALDERMAN, et al.,
Respondents.

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AMICI CURIAE BRIEF OF THE NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS AND FORTY FIVE INDIVIDUAL STATE DEVELOPMENTAL DISABILITIES PROTECTION AND ADVOCACY SYSTEMS UNDER 42 U.S.C. §6012 FROM THE STATES OF ALABAMA, ALASKA, ARIZONA, ARKANSAS, CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, DISTRICT OF COLUMBIA, FLORIDA, GEORGIA, HAWAII, IDAHO, ILLINOIS, IOWA, KANSAS, KENTUCKY, LOUISIANA, MAINE, MARYLAND, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW HAMPSHIRE, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OREGON, PENNSYLVANIA, PUERTO RICO, RHODE ISLAND, TENNESSEE, TEXAS, UTAH, VERMONT VIRGIN ISLANDS, WEST VIRGINIA, WISCONSIN, AND WYOMING

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Advocacy Services, Inc. (Arkansas)
Protection and Advocacy, Inc. (California)
Legal Center for Handicapped Citizens, Inc. (Colorado)
Office of Legal Protection and Advocacy for Handicapped and Developmentally Disabled Persons (Connecticut)
Community Legal Aid Society, Inc. (Delaware)
Information Center for Handicapped Individuals (District of Columbia)
Governor's Commission on Advocacy for Persons with Developmental Disabilities (Florida)
Georgia Advocacy Office, Inc.
Protection and Advocacy of Hawaii
Idaho's Coalition of Advocates for the Disabled
Illinois Developmentally Disabled Advocacy Authority
Protection and Advocacy Division of Iowa Civil Rights Commission
Kansas Advocacy and Protective Services for the Developmentally Disabled, Inc.
Office of Public Advocacy (Kentucky)
Advocates for the Developmentally Disabled (Louisiana)
The Advocates for the Developmentally Disabled (Maine)
Maryland Advocacy Unit for the Developmentally Disabled
Michigan Protection and Advocacy Service for Developmentally Disabled Citizens
Developmentally Disabled Advocacy Project (Minnesota)
Mississippi System of Protection and Advocacy for Developmentally Disabled Individuals, Inc.

Missouri Developmental Disabilities Protection and Advocacy Services,Inc.
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Developmental Disabilities Advocacy Office (Nevada)
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Department of Public Advocate (New Jersey)
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Protection and Advocacy (Puerto Rico)
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Ackerman, In Re, No. 3-379 A 60 (Ind. Ct. of App., Sept. 24, 1980) 14, 15
Addington v. Texas, 441 U.S. 418 (1979) 8
Becker v. Hobby Horse Ranch School, Civ. 79-303 (D. Ariz., Oct. 29, 1979) 26
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Naughton v. Bevilacqua, 458 F. Supp. 610, (D.R.I. 1978), 605 F.2d 586 (1st Cir. 1979) 14, 17
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Shelton v. Tucker, 364 U.S. 479 (1960) 8
Specht v. Patterson, 386 U.S. 605 (1967) 8
U.S. v. Mattson, 600 F.2d 1295 (9th Cir., 1979) 17
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Developmental Disabilities Services and Facilities Construction Amendments of 1970, Pub. L. No. 91-517, 84 Stat. 1316 (1970) 5
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Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282 (1963) ... 4, 5, 18
Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965, Pub. L. No. 89-105, 79 Stat. 427 (1965) 5
Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978, Pub. L. No. 95-602, 92 Stat. 2955 (1978) .. 9, 16, 23
Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965) 5

Miscellaneous

H.R. Conf. Rep. No. 94-473, 94th Cong., 1st Sess. (1975), *reprinted in* 2 [1975] U.S.Code Cong. and Ad. News 943 *et seq* 7, 12
Sen. Rep. No. 94-160, 94th Cong., 1st Sess. 1 *et seq* (1975) ..... Passim

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H.R. Rep. No. 95-1188, 95th Cong., 2nd Sess. (1978), *reprinted in* 6 [1978] U.S. Code Cong. and Ad. New 7355 *et seq* 9, 13, 24
H.R. Rep. No. 88-694, 88th Cong., 1st Sess. (1963), *reprinted in* [1963] U.S. Code Cong. and Ad. New 1054 *et seq* 18
Sen. Rep. No. 91-757, 91st Cong., 2nd Sess. 6 (1970) 10
H.R. Rep. No. 91-1277, 91st Cong., 2nd Sess. (1970), *reprinted in* [1970] U.S.Code Cong. and Ad. News 4714 *et seq*.....10
H.R. Rep. No. 94-58, 94th Cong., 1st Sess. (1975), *reprinted in* 2 [1975] U.S. Code Cong. and Ad. News 919 *et seq* 11, 21
Sen Rep. No. 90-725, 90th Cong., 1st Sess. (1967), *reprinted in* [1967] U.S. Code Cong. and Ad. News 2061 *et seq* 19
President's Message, 88th Cong., 1st Sess. *reprinted in* [1963] U.S. Code Cong. and Ad. News 1466 *et seq*.....4, 18
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121 Cong. Rec. 16520 (1975).....22
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124 Cong. Rec. 15672 (1978).....24
Comptroller General's Report to the Subcommittee on the Handicapped, Senate Committee on Labor and Human Resources, How Federal Developmental Disabilities Programs Are Working (1980).....23, 24, 28

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Henney and Alldredge, "Protection and Advocacy in the U.S. – The First Two Years" Institute for Comprehensive Planning (1980) 25
President's Panel on Mental Retardation, "A Proposed Program for National Action to Combat Mental Retardation" (1962) 3
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INTEREST OF AMICI

This brief amicus curiae is filed, pursuant to consents filed with the Clerk, on behalf of the National Association of Protection and Advocacy Systems and forty-five individual state developmental disabilities protection and advocacy systems.

The National Association of Protection and Advocacy Systems is an organization consisting of the executive directors of the state protection and advocacy systems whose purpose is to further the human and legal rights of disabled persons, advance the interests of protection and advocacy systems, and facilitate coordination and provide mutual support among protection and advocacy systems.

Under Section 113 of the Developmental Disabilities Assistance and Bill of Rights Act of 1975, 42 U.S.C. § 6012, each state is required to have in effect a system to protect and advocate the rights of developmentally disabled individuals. That system must have the authority to pursue legal, administrative, and other appropriate remedies to insure the protection of the rights of such persons. The individual state protection and advocacy systems are organizations designated by their respective States to serve as the State's protection and advocacy agency.

As the present case concerns the enforceability of the very legislation which authorized the protection and advocacy systems and of the Bill of Rights provisions which they are charged with implementing, the *amici* have a very direct interest in the outcome of this case and significant expertise regarding the legislative history, interpretation, and impact of the legislation at issue. Failure of this Court to recognize the enforceability of the rights at stake in this case would seriously undercut the day-to-day efforts of the *amici* agencies to secure the rights of their clients and leave the protection and advocacy agencies with a mandate but no legal tools for achieving their statutory and state designated purposes.

SUMMARY OF ARGUMENT

Contrary to Petitioners' argument that the Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. §§ 6000

et seq., is solely a funding statute, the legislative scheme of the Act is two-fold—it both continues federal financial support of comprehensive planning and service programs begun under prior legislation and establishes a set of legally enforceable rights of developmentally disabled persons. That Congress fully intended to depart from strictly a funding approach is made clear from three sources: the plain language of the statute, the report of the Joint Conference Committee accompanying the legislation, and the statements of various members of Congress during the floor debates on the legislation.

Throughout its history, developmental disabilities legislation has been characterized by a sensitivity to the strengths and differences of the individual states. The mechanisms created for the enforcement of the rights in the Bill of Rights Section of the 1975 Act, 42 U.S.C. § 6010, underscore the Congressional awareness of the unique situations of the individual states. In authorizing a private cause of action and establishing Protection and Advocacy systems, Congress permitted implementation of the Bill of Rights to be accomplished on a case-by-case basis, taking into account the peculiarities of specific facts and tailoring relief to fit the nuances of the particular jurisdiction and situation.

By mandating that services to developmentally disabled persons be provided in the setting that is the least restrictive while still appropriate to the individual's needs, 42 U.S.C. § 6010(2), Congress sought to ensure that the fundamental right to liberty of such persons is not abridged by the States under the guise of providing services, treatment, or habilitation. By 1975, Congress recognized the need for more drastic measures than previous funding initiatives if developmentally disabled persons were to be given full protection of the law. In response, the Developmental Disabilities Bill of Rights, 42 U.S.C. § 6010, was enacted. The extensive legislative history of this section makes clear that Congress intended to eliminate inappropriate placement in institutions of persons with developmental disabilities.

The State Protection and Advocacy Systems have played an essential role in assuring that developmentally disabled persons obtain full protection of their legal rights. Failure to recognize the enforceability of 42 U.S.C. § 6010 in the circumstances of this case would not only destroy the enforcement

scheme established by Congress, but would seriously undercut the efforts of the P&As by leaving them with a Congressional mandate, but no legal tools for achieving their statutory and state designated purpose.

ARGUMENT

I. IN A UNIQUE AND PROMISING EXERCISE IN FEDERALISM CHARACTERIZED BY SIGNIFICANT DEFERENCE TO THE AUTHORITY AND UNIQUE CHARACTERISTICS OF THE INDIVIDUAL STATES, CONGRESS WROUGHT IN THE DEVELOPMENTAL DISABILITIES ASSISTANCE AND BILL OF RIGHTS ACT OF 1975 A SET OF ENFORCEABLE RIGHTS OF DEVELOPMENTALLY DISABLED PERSONS AND ESTABLISHED SEVERAL SPECIFIC MECHANISMS, INCLUDING PRIVATE RIGHTS OF ACTION AND STATE PROTECTION AND ADVOCACY AGENCIES, FOR THE ENFORCEMENT OF THESE RIGHTS.

A. The Plain Language and Legislative History of the Developmental Disabilities Assistance and Bill of Rights Act Make Clear that Congress Intended the Developmental Disabilities Bill of Rights to be Enforceable.

The Petitioners make much of their allegation that the Developmental Disabilities Assistance and Bill of Rights Act of 1975, 42 U.S.C. §§6000 *et. seq.* (1976), is only a funding statute and does not create enforceable rights. Petitioners Br. 14-23. There might be some merit to such a theory if Petitioners were to limit its application to Developmental Disabilities legislation prior to the 1975 Act. But in the 1975 statute, Congress acted with the clear and express intention of creating enforceable rights for developmentally disabled citizens.

1. Prior Developmental Disabilities Legislation.

In 1961 President Kennedy established a President's Panel on Mental Retardation charged with investigating and making recommendations of governmental initiatives needed regarding mental retardation. Following a one-year study, the Panel submitted to the President its report, entitled "A Proposed Program for National Action to Combat Mental Retardation," in 1962.

Based in part upon the recommendations of the Panel, President Kennedy sent to Congress, on February 5, 1963, a special message on Mental Illness and Mental Retardation. In regard to mental retardation, the President presented a proposed legislative package offering a "bold new approach" focusing on three major objectives: (1) to seek out and eradicate the causes of mental retardation; (2) to add to the underlying knowledge and skilled manpower regarding mental retardation; and (3) to strengthen and improve the programs and facilities serving mentally retarded persons. (President's Message, 88th Cong., 1st Sess. *reprinted in* [1963] U.S. Code Cong. & Ad. News 1466, 1467-68 (Feb. 5, 1963)). The President's legislative proposals were clearly conceived as funding statutes:

> [W]ith these objectives in mind . . . I am proposing a new approach . . . to mental retardation. This approach is designed, in large measure, to use Federal resources to stimulate State, local, and private action.

Id. at 1468.

In response to the President's Message, Congress enacted the gist of his recommendations in the Maternal and Child Health and Mental Retardation Planning Amendments of 1963, Pub. L. No. 88-156, § 5, 77 Stat. 275 (1963), and the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, 77 Stat. 282 (1963). These two statutes were the first in a series of mental retardation and developmental disabilities legislation which would eventually come to include the Developmental Disabilities Assistance and Bill of Rights Act of 1975.

In the Maternal and Child Health and Mental Retardation Planning Amendments, *supra*, the maternal and child health provisions of the Social Security Act were expanded to include comprehensive maternity and infant care projects aimed at high-risk mothers and designed to prevent mental retardation. This law also initiated a new program of grants to states to assist them in developing comprehensive state planning in the field of mental retardation.

With Title I of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, *supra*, Congress launched the first federal program for the construction of facilities for mentally retarded persons. Under

this statute, funds were authorized for federal grants to subsidize the costs of constructing research centers for investigating the causes and prevention of mental retardation, for grants to underwrite costs of constructing university affiliated facilities for mentally retarded people, and for formula grants to the states to pay from one-third to two-thirds of the costs of constructing facilities for the care of mentally retarded persons. In addition to these provisions relating to mental retardation facilities, Title II, entitled the Community Mental Health Centers Construction Act, provided for formula grants to the states to facilitate the construction of community mental health centers.

The programs begun under the 1963 Acts were continued and expanded slightly in the Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965, Pub. L. No. 89-105, 79 Stat. 427 (1965), and in the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965), pursuant to which funds were authorized for the states to begin implementing the comprehensive mental retardation plans developed with previous funding.

The Mental Retardation Amendments of 1967, Pub. L. No. 90-170, 81 Stat. 527 (1967), extended the programs begun under the 1963 and 1965 legislation until June 30, 1970. In addition, the 1967 Amendments established a new program of matching grants following the same formula as in the Community Mental Health Centers Construction Act to help meet the costs of construction, staffing, or services at community mental retardation centers.

In the Developmental Disabilities Services and Facilities Construction Amendments of 1970, Pub. L. No. 91-517, 84 Stat. 1316 (1970), Congress broadened its concern from simply mental retardation to also include cerebral palsy, epilepsy, or other neurological conditions requiring similar treatment. This enlarged class of persons eligible for services under the statute was denominated "developmentally disabled." To assist this expanded class of disabled persons, Congress replaced the community facilities construction and staffing grant program with a program providing formula grants to the states for comprehensive, coordinated state planning, comprehensive services, and construction of community facilities for developmentally

disabled persons. Pursuant to the requirements of the statute, each state was required to designate a state planning and advisory council, and to prepare a written State Plan which presented a detailed description of services to be rendered and funds to be expended under the Act and of plans for coordination of services rendered under other programs.

The foregoing historical sketch of federal statutory programs relative to mental retardation and developmental disabilities prior to 1975 can be summed up by noting that Congressional activity in those areas consisted almost entirely of federal grant programs to encourage the construction of facilities, training and hiring of staff, research projects, and the coordination and comprehensive planning of services to developmentally disabled persons.

2. Language and Intent of the 1975 Act and Exercise of Congessional Authority Under Section 5 of the Fourteenth Amendment.

In the Developmental Disabilities Assistance and Bill of Rights Act of 1975, 42 U.S.C. § §6000 *et seq.* (1976), Congress both continued and made a major departure from prior developmental disabilities legislation. Title I of the Act continued the funding initiatives which had characterized the previous statutes. Title II of the Act, however, added a very new dimension - - the establishment of rights. The duality of the statute's structure was described by Senator Williams, Chairman of the Committee on Labor and Public Welfare which considered and recommended passage of S. 462, 94th Cong., 1st Sess. (1975) (the Senate Bill which was the source of the Bill of Rights provisions of the Developmental Disabilities Assistance and Bill of Rights Act), at the time of the Bill's passage in the Senate:

> Title I assists States in their planning toward the provision of services to meet the needs of developmentally disabled individuals . . . . Title II of the bill sets forth a means to assure that the rights of developmentally disabled individuals will be protected.

121 Cong. Rec. 16517 (1975). Senator Williams also made clear that the departure from strictly a funding approach was fully intentional; after discussing the conditions in public residential institutions, he observed:

> While much can be said about the lack of available funds to improve conditions at these institutions, at some point the country must draw the line.

Id. at 16516 (1975). Subsequently, he declared:

> S. 462 provides a framework by which the constitutional rights of residents and other persons with developmental disabilities may be enforced.

Id. at 16517 (1975).

In instituting this establishment of rights approach, Congress proceeded in a very direct, straightforward manner. Not only is 42 U.S.C. §6010 very clear in speaking of "the rights of persons with developmental disabilities," but the Act itself is entitled the "Developmental Disabilities Assistance and *Bill of Rights* Act" (emphasis added), Sec. 111 is entitled "Rights of the Developmentally Disabled," and Title II, in which the Bill of Rights is found, is unambiguously styled "Establishment and Protection of the Rights of Persons with Developmental Disabilities." Congress was unquestionably seeking to establish rights.

As for enforceability of the Bill of Rights provisions, the Joint Conference Report accompanying the 1975 Act was the paragon of clarity in declaring that the rights listed "should be protected and assured by the Congress and the courts." H. R. Conf. Rep. No. 94-473, 94th Cong., 1st Sess. 42 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 943, 961.

The Congressional authority for enacting a Bill of Rights for developmentally disabled persons is also manifest and well-documented–Congress was exercising its power under Section 5 of the Fourteenth Amendment to enforce the rights of equal protection and of liberty. Section 5 states that "Congress shall have power to enforce, by appropriate legislation, the provisions of this article." In recommending passage of S. 462, the source of the Bill of Rights provisions, the Report of the Senate Committee on Labor and Public Welfare declared:

> The Committee is firmly convinced that Congress must take action to ensure the humane care, treatment, habilitation, and protection of mentally retarded and other persons with developmental disabilities. The Federal Government has the responsibility to provide equal protection under the law to all citizens. . . .
>
> Failure of Congress to respond to the needs of persons with developmental disabilities would make a mockery

> of our Nation's progress in such areas as equal protection and individual liberty.

S. Rep. No. 94-160, 94th Cong., 1st Sess. 32-33 (1975).

The theme of enforcement of equal protection was also voiced by many of the Bill's sponsors and advocates at the time of its passage in the Senate. Senator Jennings Randolph, who introduced S. 462 for floor consideration and who chairs the Subcommittee on the Handicapped which held public hearings regarding the Bill, stated:

> The substantive direction of our efforts is toward the goal of equal rights for all handicapped Americans. Legislation such as the Developmentally Disabled Assistance and Bill of Rights Act is one of the cornerstones to the construction of programs that will meet these goals.

121 Cong. Rec. 16515 (1975). Senator Javits declared:

> Progress toward recognition of the basic human and civil rights of the mentally retarded and other developmentally disabled persons has been slow. The Federal Government has largely abrogated its responsibility in this regard and recently the greatest initiatives have come from our courts. . . .
>
> Congress should reaffirm its belief in equal rights for all citizens—including the developmentally disabled. Congress should provide the leadership to change the tragic warehousing of human beings that has been the product of insensitive Federal support of facilities providing inhumane care and treatment of the mentally retarded. The Bill of Rights of S. 462 represents this new direction and begins this reaffirmation.

Id. at 16519. See also remarks of Senator Stafford, 121 Cong. Rec. 16516 (1975).

Moreover, in addition to implementing the right of equal protection, Congress was enforcing the Fourteenth Amendment's guarantee of due process protection for the right of liberty, expounded in previous decisions of this Court.[1] In

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[1] *Addington v. Texas*, 441 U.S. 418, 425 (1979); *Ingraham v. Wright*, 430 U.S. 651, 672-674 (1977); *O'Connor v. Donaldson*, 422 U.S. 563, 573-576 (1975); *Jackson v. Indiana*, 406 U.S. 715, 738 (1972); *Humphrey v. Cady*, 405 U.S. 504, 511-512 (1972); *In re Gault*, 387 U.S. 1, 50 (1967); *Specht v. Patterson*, 386 U.S. 605, 608 (1967).

Shelton v. Tucker, 364 U.S. 479, 488 (1960), this Court declared:

> In a series of decisions this Court has held that, even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of the legislative abridgment must be viewed in the light of less drastic means for achieving the same basic purpose.

It is precisely to require the states to comply with this framework for protecting the right of liberty that Congress declared as part of the Developmental Disabilities Bill of Rights a right "to have treatment, services, and habilitation provided in the setting that is least restrictive of the person's personal liberty," 42 U.S.C. § 6010(2).

In implementing the rights to equal protection and to liberty under the Fourteenth Amendment in regard to the class of developmentally disabled persons, whom it found to have suffered severe deprivations of these rights in the past, Congress was clearly acting within the scope of its authority under Section 5. Its creation of statutory rights designed to ameliorate deprivations of underlying constitutional rights is exactly the type of legislative action contemplated by Section 5.[2]

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[2]The Congressional intent to create enforceable rights and, thereby, to give rise to a rights/funding duality in the enforcement approaches utilized in the developmental disabilities legislation was underscored with the enactment of the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, P.L. 95-602, 92 Stat. 2955 (1978). The only amendment made to the Bill of Rights by the 1978 Act was a clarification that the rights listed there "are in addition to any constitutional or other rights otherwise afforded to all persons." 42 U.S.C. § 6010, P.L. 95-602, § 507, 92 Stat. 3007. So not only did Congress not shrink away from recognizing that it had created an enforceable Bill of Rights for developmentally disabled individuals in its 1975 Act, but it went even further and declared that the rights listed in the D. D. Bill of Rights are only *some* of the enforceable rights possessed by disabled persons. See also, H.R. Rep. No. 95-1188, 95th Cong., 2d Sess. 7 (1978) *reprinted in* 6 [1978] U.S. Code Cong. & Ad. News 7355, 7362.

In 1980, Senator Javits described Congressional understanding of the purpose and effect of the D. D. Bill of Rights in debates concerning the creation of a similar bill of rights for mentally ill persons:

B. To Achieve Enforcement of the Developmental Disabilities Bill of Rights, While Respecting the Sovereignty and Diversity of the States, Congress Created a Private Right of Action and Authorized the Establishment of State Protection and Advocacy Systems.

1. Respect for States' Rights.

Throughout its history, federal mental retardation and developmental disabilities legislation has been characterized by a sensitivity to the strengths and differences of the individual states. A 1970 Senate Committee Report termed the interaction between the federal government and the states in the Developmental Disabilities program a "partnership":

> One of the most significant characteristics of State plans for the retarded is their individuality. The 50 States have their own priorities based on historical, geographical, or other differences. Each State plan has its strengths and its weaknesses, but all States are ready to move forward. To nurture this potential and realize its fulfillment, the Nation needs evidence of a continuing Federal commitment to the idea of a State-Federal partnership in this area. That commitment must be at least strong as has been manifested in other major areas of Federal involvement, such as health, education and rehabilitation.

S. Rep. No. 91-757, 91st Cong., 2nd Sess. 6 (1970). See also H.R. Rep. No. 91-1277, 91st Cong., 2nd Sess. (1970), *reprinted in* [1970] U.S. Code Cong. & Ad. News 4714, 4719.

The Developmental Disabilities Assistance and Bill of Rights Act of 1975 continued the comprehensive state formula grant programs which offered such opportunities of state-by-

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Footnote 2 continued.

What I tried to do originally was to parallel the experience which we had with the developmentally disabled, in which we found such outrageous conditions on the State level as to assail our consciences so deeply that we had to have some uniform rule respecting the basic and most elementary rights in the United States. And that has worked. We have not had a great deal of litigation under that legislation, which incorporated a set of rights which we gave the individual.

July 24 Cong. Rec. S. 9735 (1980).

state tailoring of funding and services to local needs and conditions. Indeed, a House Committee Report accompanying the 1975 Act was very laudatory toward the formula grant program, calling it "a new, innovative approach to the provision of services to a population such as that with developmental disabilities," applauding the responsibility at state level for developing implementation strategies and the "flexibility" and "variation" among the states this entailed, and praising "the high proportion of funds used for the actual provision of services, the wide variety of different services which have been provided and the large number of individuals who have benefited." H. R. Rep. No. 94-58, 94th Cong., 1st Sess. (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 919, 922-923.

But whatever positive aspects there were in the state developmental disabilities programs, the 94th Congress concluded that these were no substitute for recognition and implementation of enforceable legal rights of disabled persons. Consequently, while continuing the "state-federal partnership" in the developmental disabilities formula grant programs, Congress agreed with Senator Williams that "at some point the country must draw the line," 121 Cong. Rec. 16516 (1975), and accordingly it enacted the Developmental Disabilities Bill of Rights.

The Bill of Rights provisions of Title II of the 1975 Act, 42 U.S.C. § 6010, resulted from a compromise worked out in a Joint Congressional Conference. The House version of the Act, H.R. 4005, did not include any Bill of Rights section. The version which passed the Senate, S. 462, included a very lengthy and detailed set of rights of developmentally disabled individuals, comprised of some 117 sections and covering some 336 pages. See S. Rep. No. 94-160, 94th Cong., 1st Sess. 46-76 (1975). Moreover, each of the individual sections was not merely a broad, general statement, but rather a detailed exposition of relatively explicit requirements.

Enactment of the Senate's Bill of Rights would, therefore, have engendered something of a federal preemption of the area of facilities and services for developmentally disabled persons. For, whatever the merit of the substantive requirements in the

Senate bill, it is clear that they would have essentially mandated a high degree of uniformity and standardization in the structure and operation of residential facilities and community services in all the states. Such an eventuality would surely have resulted in improvement in many facilities and services, but at the expense of the states' diversity and individual prerogatives.

In its wisdom, however, Congress decided not to supersede the sovereignty of the states so extensively. The process by which a compromise was reached was sketched in the Joint Conference Report:

> The conference substitute contains a compromise which specifies rights of the developmentally disabled, requires programs assisted under the Act to have individual habilitation plans for those they serve, and requires the States to develop programs for protection and efficacy of the rights of the developmentally disabled. . . . The compromise is drafted as a second title in the conference substitute which amends the Developmental Disabilities Act. . . .
>
> These rights are generally included in the Conference substitute in recognition by the conferees that the developmentally disabled, particularly those who have the misfortune to require institutionalization, have a right to receive appropriate treatment for the conditions for which they are institutionalized, and that this right should be protected and assured by the Congress and the courts.

Joint Explanatory Statement of the Committee of Conference, H. R. Conf. Rep. No. 94-473, 94th Cong., 1st Sess. 41-42 (1975), *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 943, 961.

Hence, instead of a wholesale overriding of the authority and options of the states by enacting the detailed Senate provisions, the conferees forged a compromise which established certain important rights of developmentally disabled citizens and made these rights enforceable, but still left open to the states opportunities for implementation tailored to the specific needs and peculiar features of particular states. As a result, the Developmental Disabilities Assistance and Bill of Rights Act of 1975 pursues a multi-faceted approach. In Title I of the Act, it continued the program funding aspect of prior developmental

disabilities legislation. At the same time, it specified program standards with which applicants for funds were required to comply to maintain their grant eligibility, 42 U.S.C. §6010(3), (4). In addition, and, most importantly for the purpose of this case, it created mechanisms for the enforcement of the Bill of Rights provisions which take into account the authority and individual differences of the states. In authorizing a private right of action for enforcement of the Developmental Disabilities Bill of Rights, to be discussed in subsection 2 below, Congress permitted implementation of the Bill of Rights to be rendered on a case-by-case basis which takes into account the particular facts and circumstances of the individual situation, and which allows tailoring of relief to fit the peculiarities and nuances of the situation. This is in great contrast with the approach of S. 462 which would have imposed, by federal fiat, uniform structures and practices upon all of the states.

Secondly, to assure that developmentally disabled persons are able to make use of the judicial and administrative machinery available for the enforcement of their rights, Congress created the state Protection and Advocacy Systems (*amici* herein), to be discussed in subsection 3 below, 42 U.S.C. §6012. These Protection and Advocacy Systems have been developed and designated by the individual states according to their needs and desires. The diversity in the structures selected by the states for their Protection and Advocacy agencies was noted in a House Committee Report in 1978:

> There has been substantial variation among the States in the organizational framework they have chosen to carry out this task: 16 States have placed the system within an arm of government (often a department of consumer affairs, a public advocate, or a human rights commission), 1 in a university; 10 have contracted with existing organizations (such as legal aid and the State bar association), and 25 States have new nonprofit organizations established for the sole purpose of carrying out the protection and advocacy functions.

H. R. Rep. No. 95-1188, 95th Cong., 2nd Sess. 5 (1978), *reprinted in* 6 [1978] U.S. Code Cong. & Ad. News 7355, 7359-7360.

The enforcement mechanisms in the 1975 Act are thus very states' rights oriented and, in arguing against the enforcement of the Developmental Disabilities Bill of Rights, Petitioners Br. 11-23, Petitioners should consider that the Congressional alternative to the current formulation is a much more instrusive and onerous delineation of specific requirements on the states as represented by S. 462.

2. Private Right of Action.

Throughout § 6010 and in other parts of the 1975 and 1978 Acts, the rights are referred to as "rights of persons with developmental disabilities" or "rights of the developmentally disabled"; the rights created clearly belong to individual persons and are not merely "standards" or funding prerequisites. See pp. 6-9, *supra*. It seems clear therefore that § 6010 was intended by Congress to create personal rights which are judicially enforceable.

Petitioners' argument that §6010 should only be enforceable by administrative action by the Secretary of Health and Human Services, Petitioners Br. 28-34, thus flies in the face of the express language of the Act and explicit Congressional intent. There is a drastic discrepancy between Petitioners' theory and the statute itself. Indeed, if Petitioners were correct subsections (1) and (2) of §6010 would be meaningless and duplicative of subections (3) and (4) of §6010. On the contrary, however, the statute makes clear the dichotomy intended between subsections (1) and (2) and subsections (3) and (4). The first two subsections create legal rights belonging to developmentally disabled persons, while the latter subjections provide a framework of administratively enforceable requirements for funding recipients. This dichotomy in §6010 was noted by the Third Circuit Court of Appeals in the present case, and by the other federal court which has considered the issue, *Naughton v. Bevilacqua*, 458 F. supp. 610, 616 (D.R.I. 1978) *aff'd.* 605 F.2d 586 (1st Cir. 1979). See also *In re Ackerman*, No. 3-379A 60 (Ind. Ct. of App., Sept. 24, 1980). So, in addition to whatever ramifications §6010 may have regarding eligibility for federal funding, it also gives enforceable rights to developmentally disabled persons.

The enforcement of § 6010 on behalf of a developmentally disabled person falls squarely within this Court's ruling in *Maine v. Thiboutot*, ____ U.S. ____, 100 S.Ct. 2502 (1980), that 42 U.S.C. § 1983, which provides a private right of action for state "deprivation of any rights, privileges, or immunities secured by the Constitution and laws," applies to diverse federal statutes. *Id.* at 100 S.Ct. 2504. Indeed, an action under § 6010 was clearly within the scope of § 1983's purview even prior to the clarification given by the *Maine v. Thiboutot* ruling, because § 6010 explicitly grants "rights" to the affected class and, as discussed in section A(2) above, because § 6010 is designed to enforce the right of equal protection under the Fourteenth Amendment. Thus, unlike the Social Security provision at issue in *Maine v. Thiboutot*, § 6010 is a "federal equal civil rights law," *Greenwood v. Peacock*, 384 U.S. 808, 829-830 (1966), and could be considered within the scope of § 1983 even under the reasoning of the dissenting opinion in *Maine v. Thiboutot*, *Id.* at 100 S.Ct. 2507-2519 (Powell, J., dissenting).[3]

3. State Protection and Advocacy Systems (P & As).

Section 6012 of 42 U.S.C. requires each state to have "a system to protect and advocate the rights of persons with developmental disabilities." The statute specifies further that "such system must (a) have the authority to pursue legal, administrative, and other appropriate remedies to insure the protection of the rights of such persons who are receiving treatment, services,

[3]The clearly expressed intent of Congress to create enforceable rights combined with the application of § 1983 means that developmentally disabled persons were *explicitly* afforded a private right of action under § 6010. There is thus no necessity for considering the criteria under *Cort v. Ash*, 422 U.S. 66, 78 (1975), for the existence of an *implicit* private right of action. See Petitioners' Br. 29, n. 49. It is worth noting, however, that the Third Circuit Court of Appeals, acting prior to this Court's decision in *Maine v. Thiboutot*, held in the present case that the *Cort v. Ash* criteria were met and an implicit private right of action did exist. The court in *Naughton v. Bevilacqua, supra*, reached an identical conclusion that a private right of action exists under § 6010. See also, *Medley v. Ginsberg*, No. 78-2099 CH (S.D.W.Va., June 10, 1980); *In re Ackerman, supra*; and *Henkin v. South Dakota Dept. of Soc. Services*, No. CIV 78-4088 (D.S.D. Sept. 26, 1980).

or habilitation within the State, (b) not be administered by the State Planning Council, and (c) be independent of any agency which provides treatment, services, or habilitation to persons with developmental disabilities." *Id.*[4]

The legislation mandated that the P&As were to be in effect as of October 1, 1977, and by the time of the 1978 Amendments to the Developmental Disabilities Assistance and Bill of Rights Act, fifty-four P&As had been created and were in operation-one in each state, the District of Columbia, and in three U.S. territories.

There is a close nexus between the protection and advocacy function in 42 U.S.C. § 6012 and the private right of action under § 6010 discussed in part 2 above. In light of Congressional awareness that many persons with developmental disabilities "are not able to adequately protect their own rights," S. Rep. No. 94-160, 94th Cong., 1st Sess. 37 (1975), the private cause of action created under § 6010 would not be a completely adequate remedy for all disabled persons. The P&As were created to fill in this potential gap in enforcement of the §6010 private right of action. P&As were, therefore established to implement (among others) the provisions of §6010 by providing protection and advocacy to disabled persons who

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[4] Like § 6010 Bill of Rights provisions, the concept of state protection and advocacy systems (P&As), *amici* herein, had its origin in S. 462. As initially conceived, the Bill would have established "protective and personal advocacy agencies" which were to serve as oversight agencies with authority to monitor programs and services and investigate and render decisions on the merits of complaints. S. Rep. No. 94-160, 94th Cong., 1st Sess. 51-52 (1975).

Like § 6010, the need for advocacy services was one of the important concepts culled from the extensive provisions of Title II of S. 462 and accepted in the Joint Conference compromise which produced the Developmental Disabilities Assistance and Bill of Rights Act of 1975. In conference, however, some changes were made from the Senate's initial concept. Along with a change of name from "Protective and Personal Advocacy Agencies" to simply "Protection and Advocacy Systems," the role of the P&As was altered from that of an investigative and decision-rendering administrative agency to an advocacy agency with the "authority to pursue legal, administrative and other appropriate remedies to insure the protection of the rights of such persons." § 113 of P.L. 94-103, codified at 42 U.S.C. § 6012.

might not be able to successfully perform such an advocacy function by themselves. By mandating and funding the P&A Systems, Congress has underscored and reinforced its intent to make § 6010 enforceable. It is noteworthy that the Public Interest Law Center of Philadelphia, counsel for Respondents Pennsylvania Association for Retarded Citizens and four individual plaintiffs, was, at the time this action commenced, under contract to the Pennsylvania Protection and Advocacy System to advocate for developmentally disabled clients.

The role of the P & As in enforcing §6010 rights has been recognized by several lower courts. *Eg. United States v. Mattson*, 600 F.2d 1295, 1299 (9th Cir. 1979); *United States v. Solomon*, 563 F.2d 1121, 1125 (4th Cir. 1977); *Naughton v. Bevilacqua, supra; Goldstein v. Coughlin*, Civ. 79-256 (W.D.N.Y., Sept. 25, 1979). In both the *Naughton v. Bevilacqua* and *Goldstein v. Coughlin* cases, *supra*, the courts considered the standing of state protection and advocacy systems to bring suit to enforce the Developmental Disabilities Bill of Rights and in each instance the court held that P & As did have such standing. The *Goldstein v. Coughlin* court held that, as the "designated advocacy system" for the state of New York with the Congressional purpose of providing "legal representation," the P & A need show no injury to itself in order to have standing in such an action. *Id.* at 3. In *Naughton v. Bevilacqua, supra*, the court determined that the Rhode Island Protection and Advocacy System had standing to intervene as a party-plaintiff in an action involving enforcement of 42 U.S.C. §6010. Further, the court added that "the advocacy agency and a private right of action are crucial to protect the rights secured by the Act." *Id.* at 458 F. Supp. 616.

The importance of the P & A function in implementing the rights established under §6010's Bill of Rights provisions was also underscored by Senator Kennedy, Chairman of the Senate Judiciary Committee, in arguments made on behalf of P & A continuation funding in 1978:

> . . .the only way change is going to be brought about is the long, difficult, persistent and dedicated advocacy of those who are prepared to follow through administrative hearings, through hearings on regulations, through challenges in the courts, for the rights which are guaranteed in this legislation. That is the way it is done.

124 Cong. Rec. 15663 (1978).

For all of these reasons, it is clear that the private right of action and the state protection and advocacy agencies were intended by Congress as a potent, mutually supportive combination of mechanisms for the enforcement of § 6010.

II. AMONG THE RIGHTS PROTECTED IN THE DEVELOPMENTAL DISABILITIES BILL OF RIGHTS IS THE RIGHT TO HAVE TREATMENT, SERVICES AND HABILITATION PROVIDED IN THE SETTING THAT IS THE LEAST RESTRICTIVE OF THE PERSON'S PERSONAL LIBERTY.

Section 111(2) of the Developmental Disabilities Assistance and Bill of Rights Act plainly states that:

> [t]he treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is the least restrictive of the person's personal liberty.

42 U.S.C. § 6010(2).

From its beginning in 1963 with the passage of the Mental Retardation Facilities and Community Mental Health Centers Act, Pub. L. No. 88-164, 77 Stat. 282 (1963), developmental disabilities legislation consistently has focused upon improving the plight of the thousands of individuals confined to large residential institutions because of disability.

In inspiring the 1963 Act, President Kennedy, in his address to Congress on February 5, 1963, called upon Congress to

> move from the outmoded use of distant custodial institutions to the concept of community-centered agencies that will provide a coordinated range of timely diagnostic, health, education, training, rehabilitation, employment, welfare and legal protection services.

President's Message, 88th Cong., 1st Sess., *reprinted in* [1963] U.S. Code Cong. & Ad. News 1466, 1474 (Feb. 5, 1963). And the 1963 Act did reflect this community-oriented approach. See H.R. Rep. No. 88-694, 88th Cong., 1st Sess., *reprinted in* [1963] U.S. Code Cong. & Ad. News 1054, 1062.

In 1967, Congress definitively expressed its approval for community support services for mentally retarded persons

with the passage of the Mental Retardation Amendments, Pub. L. No. 90-170, 81 Stat. 527 (1967), which provided states Federal financial incentives to develop, construct and staff community mental retardation facilities. The Senate Labor and Public Welfare Committee, citing to advances in research in the cause and treatment of mental retardation, stated, "it is possible, through programs enacted by Congress and by the States, and through private voluntary agencies, to make it possible for a much larger number of the retarded to live with some degree of decency and normalcy in our society." S. Rep. No. 90-725, 90th Cong., 1st Sess., *reprinted in* [1967] U.S. Code Cong. & Ad. News 2061, 2062.

By 1975, Congress had had ample time to reflect upon the success of its efforts to decrease the need for custodial institutions for developmentally disabled persons. The Senate Committee on Labor and Public Welfare vividly expressed its displeasure with the lack of progress in developing community services in its report accompanying S. 462:

> It is now almost 50 years since experts in the field of mental retardation first began to talk about alternatives to large institutions. Unfortunately, progress in developing these community alternatives continues to be slow and—as this Committee repeatedly heard in dramatic testimony from witnesses—the care provided in institutions almost always still leaves much to be desired.

S. Rep. No. 94-160, 94th Cong. 1st Sess. 27 (1975). The Committee explicitly deplored the conditions existing in large residential institutions, repeatedly quoting from and citing to graphic descriptions of institutional life. The institutions were referred to as " 'hopeless places' dedicated to custodial care of lifelong residents." *Id.* at 28.

No doubt was left about the Committee's belief that the process of institutionalization must be halted:

> It must be recognized that the vast majority of developmentally disabled persons and the vast majority of persons now institutionalized should not be in institutions at all. Efforts to assure proper treatment, education, and habilitation services should not deflect attention from the fact that most of these institutions themselves are anachronisms, and that rapid steps must be taken to phase them

> out. Many of these institutions by their very nature, their size, their isolation, their impersonality, are unsuitable for treatment, education, and habilitation programs.

Id. at 32-33. In the face of such dissatisfaction, the Developmental Disabilities Bill of Rights was enacted.

Concern that the enactment of a set of standards of care to be met in institutional settings would be confused as Congressional approval of institutionalization prompted the Committee to report:

> . . .the intent of this legislation is not only to improve care in residential facilities, but also to minimize inappropriate admissions and to stimulate the States to develop alternative programs of care for mentally retarded and other developmentally disabled persons. It is clear that the provision of adequate and humane care in large State institutions, alone, is not an adequate answer to the problem. Other initiatives must include cutting off the flow of residents into such institutions by development of community alternatives. . . .
>
> The Committee feels that the standards set forth. . . are minimum standards to insure basic human dignity where institutional care for developmentally disabled persons is found. It is not, however, the Committee's intent that enactment of [these standards] should be construed in any way to constitute support of institutionalization of the mentally retarded.

Id. at 33.

The concerns expressed by the Committee were echoed on the floor of the Senate when S. 462 was brought forward for debate and approval.[5] Senator Williams stated that

> . . .the horrible conditions which exist in most of the public residential institutions for the mentally retarded and other developmentally disabled persons have provided shocking testimony to the inhuman ways we care for such persons.

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[5] While the Senate was considering S. 462, the House of Representatives had before it H.R. 4005, 94th Cong., 1st Sess. (1975), a bill designed to extend and expand the programs begun under the 1970 Act. While H.R. 4005 did not contain extensive detailed standards for residential and commercial facilities as in the Senate bill, it plainly supported the development of community-based alternatives to institutionalization. In a significant

121 Cong. Rec. 16516 (1975). Among the abuses occurring at such institutions, he cited that of "[i]nappropriate admissions because of lack of community services." *Id.* Senator Javits declared the purpose of the bill to include "encouraging deinstitutionalization and normalization." *Id.* at 16518. He also observed that the bill was designed to "change the tragic warehousing of human beings that has been the product of insensitive Federal support of facilities providing inhumane care and treatment of the mentally retarded." *Id.* at 16519.

When the compromise legislation, worked out in conference, was presented to Congress for its consideration, strong support was offered for the goals expounded in the bill. Senator Schweiker, citing the need for the legislation, stated:

> [t]he developmentally disabled in this Nation for too long have been treated as burdensome problems, rather than with the affection and care they deserve as human beings. Too often developmentally disabled persons are "put away" in institutions and forgotten. It is now time to provide alternatives to locking people up in institutions.

121 Cong. Rec. 29820-21 (1975). Senator Williams described the bill as assisting "in the process of deinstitutionalization and the protection of rights of persons with developmental disabilities." *Id.* at 29821. See also remarks of Sen. Javits, 121 Cong. Rec. 29820 (1975).

A major effect of 6010(2) is to require the States to provide community services in lieu of institutionalization where such services can meet the needs of the disabled person. Congress has defined the term "alternative community living arrangement services" as "such services as will assist persons with developmental disabilities in maintaining suitable residential

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Footnote 5 Continued.

revision of the 1970 Act, the House legislation required the States to spend a specified percentage of their federally allotted dollars "for programs for deinstitutionalization of persons with developmental disabilities inappropriately placed in institutions." H.R. Rep. No. 94-58, 94th Cong., 1st Sess. 1, *reprinted in* 2 [1975] U.S. Code Cong. & Ad. News 919. In reporting on H.R. 4005, the House Committee on Interstate and Foreign Commerce applauded the efforts on the part of the developmental disabilities programs to establish, assure, and preserve the rights of disabled persons including "the right to live under conditions least restrictive to personal liberty." *Id.* at 925.

arrangements in the community." 42 U.S.C. §6001(8) (E). These support services include "in-house services (such as personal aides and attendants and other domestic assistance and supportive services), family support services, foster care services, group living services, [and] respite care." *Id.*

This requirement of §6010(2) that the states develop and implement alternatives to large-scale institutions for the appropriate treatment of persons with developmental disabilities was underscored clearly by Senator Javits in 1975:

> Mr. President, I believe one very clear basic goal has been enunciated in the legislation reported from committee. That is the need to move away from institutionalization of individuals with development of community-based programs utilizing all community resources related to treatment or habilitation of such individuals to provide comprehensive services in the home community.

121 Cong. Rec. 16520 (1975).

III. A DECISION FOR PETITIONERS ON THIS APPEAL WOULD FRUSTRATE CONGRESSIONAL AND STATE INTENT, UNDERCUT EFFORTS BY STATE PROTECTION AND ADVOCACY SYSTEMS TO ENFORCE THE RIGHTS OF THEIR CLIENTS, AND LEAVE THE PROTECTION AND ADVOCACY AGENCIES WITH A MANDATE BUT NO LEGAL TOOLS FOR ACHIEVING THEIR STATUTORY AND STATE DESIGNATED PURPOSES.

A. Accomplishments of State Protection and Advocacy Systems Enforcing the Rights of Developmentally Disabled Persons.

The State Developmental Disabilities Protection and Advocacy Systems (P & As), *amici* herein, are charged by federal statute and by their state designations with a very important mission - - that of advocating for and protecting the rights of developmentally disabled citizens. 42 U.S.C. §6012; see pp. 15-18, *supra.* In 1978, when continuation funding levels for the P & As were being considered, Senator Kennedy declared:

> The establishment of a protection and advocacy system for the developmentally disabled in 1975 marked a major advance in the movement to assure that the human and legal rights of all developmentally disabled persons would be secured.
>
> No struggle to proclaim and demand fundamental human rights has been harder or more tragic than the struggle of the developmentally disabled, for among such persons - - the mentally retarded, the autistic, the cerebral palsied - - are found some of those most victimized by society's prejudices and least able to be heard effectively.
>
> The P&A system was developed after careful and extensive congressional review of outrageous violations of the rights of the developmentally disabled.

124 Cong. Rec. 15663 (1978). And a General Accounting Office report issued in 1980 concluded that "the State Protection and Advocacy Program could be the most potent and effective mechanism to insure that the developmentally disabled receive the benefits, services, and rights they are entitled to." "How Federal Developmental Disabilities Programs Are Working: Comptroller General's Report to the Subcommittee on the Handicapped, Senate Committee on Labor and Human Resources," 72 (Feb. 20, 1980) (hereinafter G.A.O. Report).[6]

A major problem of the P & As has been inadequate funding resources. *Id.* In its three years of existence, the P & A program has received only "bare-bones" federal funding while outside funding sources for P & A activities have been difficult

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[6]The performance of the P&As in their role of enforcing the Developmental Disability Bill of Rights and other rights of developmentally disabled persons was endorsed by Congress in the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, Pub. L. 95-602, which not only continued the existing P&A program but also authorized the establishment of an additional system "to protect and advocate the rights of severely handicapped individuals," as part of the statutory program of Comprehensive Services for Independent Living under the Rehabilitation Act. 29 U.S.C. § 796g. By replicating the protection and advocacy concept, Congress showed its satisfaction with the role that P&As were playing and sought to afford a similar protection and advocacy service for other citizens.

to obtain. *Id.* at 65-68, 72;H.R. Rep. No. 95-1188, 95th Cong., 2d Sess. 5-6 (1978); see also 124 Cong. Rec. 15663, 15672 (1978). In spite of these difficulties, however, P & As have been able to achieve many concrete accomplishments in protecting the rights of persons with developmental disabilities.

Some of the general types of activities in which P&As have engaged were noted in a House Committee report accompanying the 1978 Developmental Disabilities legislation:

> information and referral, legal remedy pursuits to protect individual rights, "non-legal" advocacy such as advocacy training, assistance to citizen advocacy projects, and encouraging self-advocacy, and various class advocacy activities aimed at systems reform.

H. R. Rep. No. 95-1188, 95th Cong., 2d Sess. 5 (1978), *reprinted in* 6 [1978] U.S. Code Cong. & Ad. News 7355, 7359-7360. The G.A.O. Report, *supra*, noted:

> Two factors which distinguish this program from others–independence and power–also are the key to its success. Being independent of other administering or service agencies, the State Protection and Advocacy Program gives the developmentally disabled a way to work outside established service delivery systems to contest their rights. More importantly, where needed services are not being provided, program advocates can intercede on behalf of the disabled and compel others to furnish such services.

Id. at 72.

Of the overall success of the P & As, Senator Kennedy observed in 1978 that it is a program "which has been extremely successful and which the States, themselves, have warmly embraced and which the handicapped people and the developmentally disabled people of this Nation warmly endorse." 124 Cong. Rec. 15663 (1978). He added that "the evaluation of the existing programs has shown some of the most dedicated, committed individuals involved in these programs," *Id.* And further, "[i]t is a program which is building upon a solid record of achievement and accomplishment. It has wide and broad support of the people that have been affected . . ." *Id.*

A report issued by the Institute for Comprehensive Planning in March of 1980 found that P & As had served some 44,000 developmentally disabled persons during their first two

years of operation. Henney and Alldredge, "Protection and Advocacy in the United States - - The First Two Years," 3, Institute for Comprehensive Planning (March 1980) (hereinafter I.C.P. P & A Report). Of this large number of persons served, only a very small proportion of the cases necessitated legal action, indicating that P & As have not been at all litigation "trigger-happy." Less than 7 percent of the cases handled by P & As during their first two years required legal remedies such as administrative hearings, due process hearings, and court action. *Id.* at 12. And only 1.5 percent of the cases handled involved actual court proceedings. *Id.* The report concluded that "the fact that Protection and Advocacy has used the legal redress judiciously underscores the maturity that this unique and dynamic system has attained in its first two years of operation." *Id.* at 12-13.

The statistics as to the large numbers of individuals served by the P & As can be made more meaningful by a delineation of some concrete, specific examples of the ways in which P & As have helped developmentally disabled clients.

In Maryland, for instance, the Protection and Advocacy system was instrumental in obtaining the release of and appropriate programming for a mentally retarded man who had been misdiagnosed as mentally ill and confined in state mental hospitals for 37 years. He had stopped talking, stopped feeding himself and exhibited other regressive behavior while at the mental facilities. With P & A assistance and the cooperation of state agencies, the Quiet Man (as he came to be called) was allowed to enter a program in the community for mentally retarded persons, where he has not only regained the ability to talk and feed himself but has made much progress in social skills and other areas. Investigation by the Maryland Attorney General has disclosed that the Quiet Man is only one of a number of mentally retarded people being improperly confined in mental illness facilities; the P & A is presently working with the Attorney General's office to assist these persons. The Quiet Man currently lives in the community with an aunt.

In Hawaii, the P &A has placed a staff person and opened a branch office in Calipappa on the island of Molokai to assist the approximately 130 severely handicapped persons who are

the remnants of the once infamous leper colony. Calipappa is located in an extremely isolated site with cliffs barring access except by mule train or helicopter. The P & A is seeking to arrange improved medical care and to secure for the severely disabled residents various state services for which they are eligible.

The Arizona P & A, in conjunction with a state licensing agency, secured the closing of a private nursing facility where thirteen mildly mentally retarded residents had been housed in allegedly extremely substandard and even bizarre circumstances, including the confinement of residents in a corral, stock pens and commodes. *Becker v. Hobby Horse Ranch School*, Civ. 79-303 (D. Ariz. Oct. 29, 1979). After the facility was closed, the Arizona P & A worked successfully with several other state P & As to arrange alternative placements for the residents of the facility.

Several P & As have worked to overcome potential zoning problems and restrictive covenants which have hampered the development of community living arrangements. In *Bellarmine Hills Association v. The Residential Systems Co.*, 84 Mich. App. 554 (1978), for example, the Michigan P & A was able to have a planned foster home for six mentally retarded children upheld as a single family residence complying with a restrictive covenant on the property. The court stressed the important public policy of supporting residential alternatives to institutionalization. And in a somewhat similar context, the Illinois P & A succeeded in reversing a Chicago Zoning Board of Appeals decision which would have denied a special permit for a building to be used for a group home for ten developmentally disabled children.

The Idaho P & A operates a community organization program which serves from 50 to 60 clients. This program involves organization and training of parents of institutionalized persons in regard to the rights of institutionalized persons. As a result of this program, parents initiated negotiations with the administration of a local institution to increase programming and to improve conditions. As a result, programming has been improved and several residents have been discharged to appropriate community programs.

The Delaware P & A intervened on behalf of an older mentally retarded couple who were being denied the right to marry and to live together as husband and wife by the institution in which they both resided, even though they were legally competent and had the requisite personal and social skills to enter into marriage. The efforts of a P & A staff person advocating for the couple's legal rights succeeded in persuading the facility administrators to relent, and the couple was able to get married and to live conjointly. The P & A person not only secured the couple's legal rights, but reportedly also served as a witness and official photographer at their wedding ceremony. While such personal involvement is perhaps above and beyond the call of duty, this example is illustrative of the critical role that P & As often play in convincing service providers to respect the rights of developmentally disabled persons.

The foregoing examples are only the smallest sampling of the diverse and fruitful activities engaged in by the P & As to advocate for the rights of their clientele.[7] On a day-to-day basis, P & As have a great impact upon improvement of the quality of disabled persons' lives and in achieving implementation of their legal rights. In the words of the Institute for Comprehensive Planning P & A Report, *supra*:

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[7] In speaking in favor of continuation funding for the P&As in 1978, Senator Kennedy cited several examples of P&A activities, including the following:

> In New York, a severely mentally retarded adult had been living in the shower room of a State institution for 10 years. The shower room was equipped only with a mattress. The P&A system intervened and the young man has been relocated in another institution where a habilitation program is being developed for him.
>
> In Texas, a 27-year-old woman with cerebral palsy was being physically and sexually abused by her brother and father. The P&A system was responsible for removing her from her home and found placement for her in a community residence program, providing habilitation services.
>
> In New Jersey, a mentally retarded woman who had worked for the State government with distinction for 22 years had never been able to pass a civil service examination. As a result, she was laid off when her agency ran short of funds, even though less productive workers were kept on. The P&A system appealed her case

> The Protection and Advocacy Program, in cooperation with the other elements [of the Developmental Disabilities program], and in some cases singlehandedly, has allowed thousands of individuals who are developmentally disabled to live in a less restrictive environment, to secure an appropriate education, and to enjoy to the limits of their physical and mental capabilities activities within society that they had not heretofore realized prior to the development of the Protection and Advocacy activity within their state.

Id. at 4.

B. Potential Harm of a Decision in Favor of Petitioners.

Amici P & A agencies are very concerned that a reversal of the Circuit Court's decision in the present case would undermine the Congressional intent in enacting the Developmental Disabilities Bill of Rights, impede the intent of the states in designating their P & A agencies, and severely impair the ability of the P & As to effectively carry out their day-to-day activities. Such a situation would leave the P & As with their state and federal mandates to protect and advocate for the rights of disabled persons, but deprive them of important legal tools for accomplishing their statutory mission.

P & As have not employed a litigious approach in representing their clients; indeed, court activity has been held to an absolute minimum. One reason for the success of this non-litigation strategy has been that P & As have been able to negotiate from a position of strength in that their clients' rights were expressly spelled out in §6010. If this Court were to hold §6010 unenforceable, the negotiating position of the

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Footnote 7 continued.

to the State Civil Service Commission and arranged an oral examination for her. She passed it and is now a permanent employee.

In Massachusetts, a 46-year-old man with epilepsy was held in a county jail without bail for 3 months and denied medical attention and medication. As a result he had several seizures and injured himself badly. His family obtained P&A system intervention. As a result, he was released without bail pending trial.

124 Cong. Rec. 15663 (1978).

P & As and their clients would be significantly undercut. The ability of P & As to obtain voluntary compliance and compromise concessions from service providers would be reduced drastically.

Such a result would directly frustrate the specific purpose for which the individual state governments have selected and authorized their P & A systems and the express charge given these state agencies by Congress: "to protect and advocate the rights of persons with developmental disabilities." 42 U.S.C. §6012.

In order not to stultify the Congressional intent expressed in §§6010 and 6012, and the initiatives of the individual states in authorizing and appointing their P & A agencies, the decision of the Circuit Court of Appeals should be upheld.

CONCLUSION

For the foregoing reasons, the decision of the United States Court of Appeals for the Third Circuit should be affirmed.

October 17, 1980

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, ET AL.,
Petitioners

TERRI LEE HALDERMAN, ET AL.,
PENNSYLVANIA ASSOCIATION FOR RETARDED
CITIZENS, ET AL., and
UNITED STATES OF AMERICA,
Respondents

On Writ of Certiorari to the United States Court of Appeals for the Third Circuit

BRIEF FOR THE NATIONAL CENTER FOR LAW AND THE HANDICAPPED

STATE OF INDIANA PROTECTION AND ADVOCACY SERVICE COMMISSION FOR THE DEVELOPMENTALLY DISABLED

OHIO PROTECTION AND ADVOCACY ASSOCIATION AMICI CURIAE

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Cases

Brewster v. Dukakis, No. 76-4423-F (D. Mass., Dec. 6, 1978) 7

Brown v. Board of Education, 347 U.S. 483 (1954) .4, 15, 19

Davis v. Watkins, 384 F. Supp. 1196 (N.D. Ohio 1974) and 461 F. Supp. 842 (N.D. Ohio 1978) 7

Evans v. Washington, 459 F. Supp. 483 (D.D.C. 1978) 7

Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976) 7

Griswold v. Connecticut, 381 U.S. 479 (1965) 17

Halderman v. Pennhurst State School and Hospital, 446 F. Supp. 1295 (E.D. Pa. 1978), *aff'd in part and rev'd and remanded in part*, 612 F.2d 84 (1979), *cert. granted*, ___ U.S. ___, 100 S.Ct. 2984 (1980) 5, 14, 15, 28

Horacek v. Exon, 357 F. Supp. 71 (D. Neb. 1973) and No. 72-6-299 (D. Neb. 1975) 7, 24

Iasimone v. Garrahy, Civ. No. 77-0727 (D.R.I., April 6, 1979) 7

Meyer v. Nebraska, 262 U.S. 390 (1923) 17

Michigan Association for Retarded Citizens v. Smith, 475 F. Supp. 990 (E.D. Mich. 1979) 7

Moore v. City of East Cleveland, Ohio, 431 U.S. 494 (1977) 17

New York State Association for Retarded Children v. Rockefeller (Carey), 357 F. Supp. 752 (E.D.N.Y. 1973) and 393 F. Supp. 715 (E.D.N.Y. 1975) 7

TABLE OF AUTHORITIES—Continued

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O'Connor v. Donaldson, 422 U.S. 563 (1975)	14
Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania, 334 F. Supp. 1257 (E.D. Pa. 1971)	15
Pierce v. Society of Sisters, 268 U.S. 510 (1925)	17
Roe v. Wade, 410 U.S. 113 (1973)	17
Smith v. Organization of Foster Families for Equality and Reform, 431 U.S. 816 (1977)	17
Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part and vacated and remanded in part*, 550 F.2d 1122 (8th Cir. 1977)	7
Wisconsin v. Yoder, 406 U.S. 205 (1972)	17
Wouri v. Zitnay, Civ. No. 75-80-SD (D. Me. July 14, 1978)	7
Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom., Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974)	7

Statutes and Legislative Materials

Developmentally Disabled Assistance and Bill of Rights Act	
42 U.S.C. §6000 et seq.	6, 30
42 U.S.C. §6001 (7)(A)(i)	14
Education for All Handicapped Children Act	
20 U.S.C. §1401 et seq.	30
Rehabilitation Act of 1973	
29 U.S.C. §701 et seq.	30
29 U.S.C. §793	30
29 U.S.C. §794	30

TABLE OF AUTHORITIES—Continued

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121 Cong. Rec. 9978 (April 10, 1975) 6

121 Cong. Rec. 16,516 (June 2, 1975) 7, 8

121 Cong. Rec. 16,522 (June 2, 1975) 6

H.R. Rep. 58, 94th Cong., 1st Sess. 10 6

H.R. Rep. 58, 94th Cong., 1st Sess. 15 6

S. Rep. No. 160, 94th Cong., 1st Sess. 26 6

Books and Articles

Adams, Mental Retardation and Its Social Dimensions (1971) 8, 10, 12

Altman, Cleland & Swartz, *Social Responsivity in the Profoundly Mentally Retarded*, 34 Perceptual and Motor Skills 101 (1972) 21

Barrett & McCormack, *Varied-Teacher Tutorials: A Tactic for Generating Credible Skills in Severely Retarded People*, Mental Retardation Vol. II, No. 6, at 14 (December 1973) 20

Bell, *IQ As A Factor in Community Life Style of Previously Institutionalized Retardates*, Mental Retardation, Vol. 14, No. 3, at 29 (1976) 24

Bellamy, Peterson & Close, *Habilitation of the Severely and Profoundly Retarded: Illustrations of Competence*, 10 Ed. and Training of the Mentally Retarded 1974 (1975) 21

Berkson & Landesman-Dwyer, *Behavioral Research on Severe and Profound Mental Retardation*, 81 Am. J. Ment. Defic. 428 (1977) 20

Bjaanes & Butler, *Environmental Variation in Community Care Facilities for Mentally Retarded Persons*, 78 Am. J. Ment. Defic. 429 (1974) 23

TABLE OF AUTHORITIES—Continued

Page

Blatt, Exodus From Pandemonium: Human Abuse and a Reformation of Public Policy (1970) 6

Blatt, Bogdan, Biklen & Taylor, *From Institution to Community: A Conversion Model*, in Educational Programming for the Severely and Profoundly Handicapped 40 (Sontag, ed. 1977) 16

Blatt and Kaplan, Christmas in Purgatory: A Photographic Essay on Mental Retardation (1966) 6

Booth, *Early Receptive Language Training for the Severely and Profoundly Retarded*, Language, Speech and Hearing Services in the Schools, Vol. 9, No. 3 (July 1978) 20

Bronston, *Matter of Design*, in Toward Excellence: Achievements in Residential Services for Persons with Disabilities 7 (Apolloni, Cappuccilli & Cooke, eds. 1980) 22

Bruininks, Hauber & Kudla, National Survey of Community Residential Facilities: A Profile of Facilities and Residents in 1977 (Developmental Disabilities Project on Residential Services and Community Adjustment 1979) 27, 28

Bullard, *State Care of High-Grade Imbecile Girls*, Proc. Nat. Conf. Charities & Corrections 299 (1910) 10

Burgdorf & Burgdorf, *The Wicked Witch Is Almost Dead: Buck v. Bell and the Sterilization of Handicapped Persons*, 50 Temp. L.Q. 995 (1977). 11

Butterfield, *Institutionalization and Its Alternatives for Mentally Retarded People in the United States*, 6 Int. J. Ment. Health 21 (1977) 23

TABLE OF AUTHORITIES—Continued

Page

Centerwall & Centerwall, *A Study of Children With Mongolism Reared in the Home Compared to Those Reared Away from the Home*, 25 Pediatrics 678 (1960) 5

Chase, The Legacy of Malthus (1977)..... 11

Chinn, Drew & Logan, Mental Retardation: A Life Cycle Approach (2d ed. 1979) 18

Close, *Community Living for Severely and Profoundly Retarded Adults: A Group Home Study*, Educ. and Train. of the Ment. Retarded, Vol. 12, No. 3 (Oct. 1977)..... 24

Comptroller General of the United States, Report to the Congress, Returning the Mentally Disabled to the Community: Government Needs to Do More (1977) 8

Davies, Social Control of the Mentally Deficient (1930)..... 11, 12, 16

Devellis, *Learned Helplessness in Institutions*, Mental Retardation, Vol. 15, No. 5, at 10 (Oct. 1977)..... 5

Dybwad and Herr, *Unnecessary Coercion: An End to Involuntary Civil Commitment of Retarded Persons*, 31 Stan. L. Rev. 753 (1979)..... 6

Fabry & Reid, *Teaching Foster Grandparents to Train Severely Handicapped Persons*, 11 J.A.B.A. 111 (1978) 22

Fernald, *The Burden of Feeble-Mindedness*, 17 J. Psycho-Asthenics 97 (1912) 10

Fernald, *State Programs for the Care of the Mentally Defective*, 24 J. Psycho-Asthenics 114 (1919) 12

TABLE OF AUTHORITIES—Continued

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Francis, *The Effects of Own-home and Institution-rearing on the Behavioral Development of Normal and Mongol Children*, 12 J. Child Psych. & Psych. 173 (1971) 5

Galton, Hereditary Genius: An Inquiry Into Its Law and Consequences (1869) 11

Gladstone & Sherman, *Developing Generalized Behavior-Modification Skills in High-School Students Working With Retarded Children*, 8 J.A.B.A. 169 (1975) 22

Goddard, The Kallikak Family (1912) 10

Goffman, Asylums (1961) 6

Gold, *Task Analysis of a Complex Assembly Task by the Retarded Blind*, Exceptional Children, Vol. 43, No. 2, at 78 (October 1976) 21

Gollay, Freedman, Wyngaarden & Kurtz, Coming Back: The Community Experiences of Deinstitutionalized Mentally Retarded People (1978) 23

Grossman, Manual of Terminology and Classification in Mental Retardation (1973) 14

Guthrie, Butler & Gorlon, *Personality Differences Between Institutionalized and Non-Institutionalized Retardates*, 67 Am. J. Ment. Defic. 543 (1963) ... 5

Haskell, *Mental Deficiency Over a Hundred Years*, 100 Am. J. Psychiat. 107 (1944) 8

Heal, Sigelman & Switzky, *Research on Community Residential Alternatives for the Mentally Retarded*, in 9 International Review of Research in Mental Retardation 209 (Ellis, ed. 1978) 24

TABLE OF AUTHORITIES—Continued

Page

Herr, *Civil Rights, Uncivil Asylums and the Retarded*, 43 Cinn. L. Rev. 679 (1974) 6

Hooper & Wambold, *Improving the Independent Play of Severely Retarded Children*, Educ. and Train. of the Ment. Retarded, Vol. 13, No. 1 (Feb. 1978) 21

Howe, *Final Report of the Superintendent to the Trustees of the Massachusetts School for Idiotic Children* (1847), cited in President's Committee on Mental Retardation, Mental Retardation: Past and Present (Gray, ed. 1976)..... 9

Kanner, A History of the Care and Study of the Mentally Retarded (1964)..... 8

Kluger, Simple Justice (1976)..... 19

Knowlton, *The Pennsylvania System*, in Toward Excellence: Achievements in Residential Services for Persons with Disabilities 127 (Apolloni, Cappuccilli & Cooke, eds. 1980) 28, 29

Leland & Smith, Mental Retardation: Present and Future Prespectives (1974) 14, 18

Lippman & Goldberg, *Right to Education: Anatomy of the Pennsylvania Case and its Implications for Exceptional Children*..... 16

Lyle, *The Effect of an Institution Environment Upon the Verbal Development of Imbecile Children --Part I*, 3 J. Mental Deficiency Research 122 (1959) 5

Lyle, *The Effect of an Institution Environment Upon the Verbal Development of Imbecile Children-- Part II*, 4 *J. Mental Deficiency Research 1* (1960) 5

TABLE OF AUTHORITIES—Continued

Page

Lyle, *The Effect of an Institution Environment Upon the Verbal Development of Imbecile Children --Part III*, 4 J. Mental Deficiency Research 14 (1960) 5

Martin, Kehoe, Bird, Jensen & Darbyshire, *Operant Conditioning in Dressing Behavior of Severely Retarded Girls*, Mental Retardation, Vol. 9, No. 3, at 27 (June 1971) 20

Mason & Menolascino, *The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal and Scientific Interface*, 10 Creighton L. Rev. 124 (1976) 12, 14

McCarver & Craig, *Placement of the Retarded in the Community: Prognosis and Outcome*, 7 International Review of Research in Mental Retardation 145 (Ellis, ed. 1974) 23

Menolascino, Challenges in Mental Retardation (1977) 10

Miller and Miller, *The Handicapped Child's Civil Right As It Relates to the "Least Restrictive Environment" and Appropriate Mainstreaming*, 54 Ind. L. J. 1 (1978) 17

Mitchell & Smeriglio, *Growth in Social Competence in Institutionalized Mentally Retarded Children*, 74 Am. J. Ment. Defic. 666 (1970) 5

Murphy, Nuner & Hutchings-Ruprecht, *Reduction of Stereotyped Behavior in Profoundly Retarded Individuals*, 82 Am. J. Ment. Defic. 283 (1977) .. 20

National Center for Law and the Handicapped Monograph, Recent Developments in Right to Treatment and Deinstitutionalization Cases

TABLE OF AUTHORITIES—Continued

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(1979), reprinted in Amicus, Vol. 5, No. 2 (March-April 1980) 20

Nihira & Nihira, *Jeopardy in Community Placement*, 79 Am. J. Ment. Defic. 538 (1975) 23, 24

Nihira & Nihira, *Normalized Behavior in Community Placement*, Mental Retardation, Vol. 13, No. 2, at 9 (April 1975) 23, 24

Note, *Enforcing the Right to an "Appropriate" Education: The Education for All Handicapped Children Act of 1975*, 92 Harv. L. Rev. 1103 (1974) 17

O'Brien, Azrin & Boyle, *Training Profoundly Retarded Children to Stop Crawling*, 5 J.A.B.A. 131 (1972) 20

O'Neill & Bellamy, *Evaluation of a Procedure for Teaching Saw Chain Assembly to a Severely Retarded Woman, Mental Retardation, Vol. 16*, No. 1, at 37 (February 1978)..... 21

Osarchuk, *Operant Methods of Toilet-Behavior Training of the Severely and Profoundly Retarded: A Review*, 7 J. of Special Ed. 423 (1973)..... 20

Penrose, The Biology of Mental Defect (1966)..... 8, 11

Philips, Leibert & Poulos, *Employing Paraprofessional Teachers in a Group Language Training Program for Severely and Profoundly Retarded Children*, 36 Perceptual & Motor Skills 607 (1973) 22

Pickens, Eugenics and Progressives (1968) 11

Popenoe & Johnson, Applied Eugenics (1933)..... 11

TABLE OF AUTHORITIES—Continued

Page

President's Committee on Mental Retardation, Mental Retardation: Past and Present (Gray, ed. 1976) 8, 9

Provencal, *The Macomb-Oakland Regional Center*, in Toward Excellence: Achievement in Residential Services for Persons with Disabilities 19 (Apolloni, Cappuccilli & Cooke, eds. 1980) 27

Rapp & Deitz, *Reducing Aggressive and Self-Injurious Behaviors of Institutionalized Retarded Children Through Reinforcement of Other Behaviors*, 7 J.A.B.A. 313 (1974) 20

Regional Directors' Council, Nebraska Community-Based Mental Retardation Programs: Three Year Plan 1979-1982 (1980) 25, 26, 29

Retish, Hey & Boaz, *Systems Unlimited-Normalization Exemplified*, Mental Retardation, Vol. 16, No. 4 (Aug. 1978) 23

Rivera, Willowbrook: A Report on How It Is and Why It Doesn't Have to Be That Way (1972) 6

Robinson & Robinson, The Mentally Retarded Child 433 (2d ed. 1976) 10, 16, 18

Roos, *Basic Facts About Mental Retardation*, 1 Legal Rights of the Mentally Handicapped 17 (Ennis & Friedman, eds. 1973) 12

Rothman, *Reaction Comment*, in President's Committee on Mental Retardation, The Mentally Retarded Citizen and the Law 407 (Kindred, ed. 1976) 9

Sales & Frohboese, *Parental Opposition to Deinstitutionalization: A Challenge in Need of Attention*

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and Resolution, Law & Human Behavior, Vol. 4, Nos. 1-2 (1980)	25
Sarason & Doris, Psychological Problems in Mental Deficiency (1969)	11
Schlanger, *Environmental Influences on the Verbal Output of Mentally Retarded Children*, 19 J. Speech & Hearing Disorders 339 (1954)	5
Silverstein, *Changes in the Measured Intelligence of Institutionalized Retardates as a Function of Hospital Age*, 1 Development Psych. 125 (1969)	4
Sloan, *Four Score and Seven*, 68 Am. J. Ment. Defic. 6 (1963)	8
Sontag, Certo & Button, *On a Distinction Between the Education of the Severely and Profoundly Handicapped and a Doctrine of Limitations*, Exceptional Children, Vol. 45, No. 8, at 604 (May 1979)	24
Sontag, Dodd & Button, *The Education and Community Support of Severely Handicapped People*, 6 Int. J. Ment. Health 35 (1977)	22
Sternlich & Siegel, *Institutional Residence and Intellectual Functioning*, 12 J. Mental Deficiency Research 119 (1968)	4
Teitelbaum & Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application*, 12 Fam. L. Q. 153 (1978)	4
Thrasher, *Right to Treatment Litigation*, in Shaping the Future: Community-Based Residential Services and Facilities for Mentally Retarded People 95 (Roos, McCann and Addison, eds. 1980)	7

TABLE OF AUTHORITIES—Continued

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Touche Ross & Co., State of Nebraska: Cost Study of the Community Based Mental Retardation Regions and the Beatrice State Developmental Center (August 15, 1980) 26, 27

Vogel, *Effects of Environmental Enrichment and Environmental Deprivation on Cognitive Functioning in Institutionalized Retardates*, 31 J. Consulting Psych. 570 (1967) 4

Wallin, Mental Deficiency (1956) 12

Weintraub and Abeson, *New Education Policies for the Handicapped: The Quiet Revolution*, in Public Policy and the Education of Exceptional Children 78 (Weintraub, Abeson, Ballard & Lavor, eds. 1976) 15

Whelan, *We've Only Just Begun*, in Educational Programming for the Severely and Profoundly Handicapped 469 (Sontag, ed. 1977) 16

Whitney, The Case for Sterilization (1934) 11

Williams & Hamre-Neitupski, *Teaching Selected Social Skills to Severely Handicapped Students*, SALT: School Applications of Learning Theory, Vol. 8, No. 3 (April 1976) 21

Wolfensberger, *The Origin and Nature of Our Institutional Models*, reprinted from President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded (Kugel & Wolfensberger, eds. 1969) 8, 9, 10, 13

Wolfensberger, The Principle of Normalization in Human Services (1972) 12

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Wolfensberger, *Will There Always Be An Institution? II: The Impact of New Service Models*, in The History of Mental Retardation Vol. II, 415 (Rosen, Clark & Kurtz, eds. 1976) 17

INTEREST OF AMICI CURIAE

Amici curiae are organizations dedicated to ensuring the equal rights of handicapped persons through advocacy and educational services. All of these organizations have been involved in efforts to obtain appropriate and integrated community services for institutionalized mentally retarded and developmentally disabled individuals.

Through their combined expertise, *amici* have provided information, authorities and argument in an attempt to assist the Court in deciding the extremely important and complex issues presented in the case at Bar. *Amici* especially wish to assist the Court by placing the issues presented in their proper perspective and by describing the habilitational and community residential services data which provide a true picture of the nature and capabilities of mentally retarded persons.

The National Center for Law and the Handicapped is a research, advocacy and educational organization concerned with questions involving the legal rights of handicapped persons. The Center assists attorneys, organizations and individuals through direct participation in cases and through research and consultation. Assistance is often provided to courts by the filing of *amicus curiae* briefs; the Center has previously filed *amicus curiae* briefs in several cases involving handicapped persons before this Court.

The State of Indiana Protection and Advocacy Service Commission for the Developmentally Disabled and the Ohio Protection and Advocacy Association are state organizations established pursuant to the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000 *et seq.* These agencies provide legal assistance and other forms of advocacy and protection to developmentally disabled individuals.

Amici's experiences in particular states and nationwide enable them to present to this Court extremely relevant information which *amici* believe will be of benefit to the Court and not otherwise presented by the parties. The parties have consented to the filing of this Brief.

SUMMARY OF ARGUMENT

The Court is presented with a case involving the segregation of mentally retarded individuals from the mainstream of society. *Amici* submit that, given the information and data presented herein and given the Congressional legislative actions based upon such data, the Federal Court of Appeals for the Third Circuit acted quite properly in requiring individualized placement determinations utilizing a presumption that the community is the most appropriate placement.

Congress had before it extensive information concerning the harms associated with institutionalization. The literature documents the developmental harms, and a multitude of federal court cases document the highly abusive conditions within institutions, resulting in gross physical harms. Institutions, *amici* assert, can in no conceivable manner be viewed as protective, pleasant or stimulating environments. Rather, the reality of institutionalization is incredibly bleak, and Congress was well aware of this as it deliberated on its appropriate legislative response.

Amici submit that it is extremely important for this Court to recognize the historical perspective in the treatment of mentally retarded persons in this society. Mentally retarded persons have consistently been viewed as "deviants," treated harshly throughout history. Highly prejudicial and erroneous conceptions of the nature of mental retardation served to further isolate them from society, either purportedly to protect them from society or to protect society from them. In an attempt to limit the

procreation of mentally retarded persons, which was viewed in the early twentieth century as a grave threat to society, isolated and massive institutions grew and expanded.

Not until the last few decades, long after those earlier prejudicial rationales for segregation were discredited, has society begun to rectify the past injustices and begin a process of reintegration of the mentally retarded into society. Based upon increased scientific knowledge and social science developments, illustrating the importance and the successes of education and training procedures, mentally retarded persons, no matter how severe their handicaps, have a reasonable expectation to achieve, like all other individuals, their maximum growth potential.

Amici in this brief counter the attempt by groups supporting appellants to portray severely and profundly retarded persons in hopeless and paternalistic terms. *Amici* urge this Court to recognize the potential of all persons, as Congress clearly has done, in emphasizing the significance of education in broad terms. *Amici* present some of the voluminous social science data which illustrates the achievements of severely and profoundly retarded persons, from the learning of simple tasks such as self-feeding to the acquiring of complex vocational tasks.

Finally, and most significantly, this brief presents data from functioning community service systems to dispel any notion that a label of severe or profound retardation prevents that individual from successfully residing in the community. The reality reflected by the studies and the success and quality of many existing community service systems reinforce the importance of the Congressional and Third Circuit approach of individualization. *Amici* submit that, given appropriate services to meet the needs of each individual, all mentally retarded persons can without question be served in and integrated into the community.

ARGUMENT

I. NO REASONABLE RATIONALE CURRENTLY EXISTS TO SUPPORT THE SEGREGATION OF MENTALLY RETARDED PERSONS INTO ISOLATED AND HARMFUL INSTITUTIONS.

A. Segregated Placements Into Institutions Cause Harm To Mentally Retarded Individuals.

The case at Bar is quite simply a case involving the segregation from society of a class of individuals who are labeled mentally retarded. This Court, similar to the circumstances in *Brown v. Board of Education*, 347 U.S. 483 (1954), involving segregation by race, is being asked by the appellants and their *amici curiae* to uphold the widespread use of institutional segregation, despite the documented harm suffered by the segregated individuals. The appellants, however, ask even more of the Court than was requested by those supporting segregation in *Brown*— the appellants ask the Court to overturn deliberate findings which were made by Congress based upon its evaluation of all available data.[1]

The harms of institutionalization have been illustrated in numerous ways. The literature is replete with evidence[2] that institutional residents, especially children, suffer decreases in such significant areas as intelligence quotient,[3] motor skills,[4] social competence,[5] and verbal

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[1] Congressional intent and legislative history are discussed in great detail in the briefs of appellees and need not be repeated here.

[2] *See generally* Teitelbaum & Ellis, *The Liberty Interest of Children: Due Process Rights and Their Application*, 12 Fam. L.Q. 153 (1978).

[3] *See* Sternlich & Siegel, *Institutional Residence and Intellectual Functioning*, 12 J. Mental Deficiency Research 119 (1968); Silverstein, *Changes in the Measured Intelligence of Institutionalized Retardates as a Function of Hospital Age*, 1 Developmental Psych. 125 (1969); Vogel, *Effects of Environmental Enrichment and Environmental Deprivation on Cognitive Functioning in Institutionalized Retardates*, 31 J. Consulting Pysch. 570 (1967).

skills.[6] Mentally retarded persons face a significant risk that necessary skills will not be obtained while institutionalized or even that skills already acquired will be lost.[7] The record below indicates that a survey conducted at Pennhurst "revealed that 34% of the individuals in the group surveyed had some notation of regression in their records."[8]

Perhaps the greatest harm, however, is that which necessarily flows from segregation. While appellants' *amici* paint a picture of the institution as "paradise," with

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[4] *See* Francis, *The Effects of Own-home and Institution-rearing on the Behavioral Development of Normal and Mongol Children*, 12 J. Child Psych. & Psych. 173 (1971) (less visual contact and fewer types of behavior among institutionalized children); Centerwall & Centerwall, *A Study of Children with Mongolism Reared in the Home Compared to Those Reared Away from the Home*, 25 Pediatrics 678 (1960).

[5] *See* Guthrie, Butler, & Gorlon, *Personality Differences Between Institutionalized and Non-Institutionalized Retardates*, 67 Am. J. Ment. Defic. 543 (1963) (negative self-attitude); Mitchell & Smeriglio, *Growth in Social Competence in Institutionalized Mentally Retarded Children*, 74 Am. J. Ment. Defic. 666 (1970) (deterioration in social competence unless special programming provided).

[6] *See* Schlanger, *Environmental Influences on the Verbal Output of Mentally Retarded Children*, 19 J. Speech & Hearing Disorders 339 (1954); Lyle, *The Effect of an Institution Environment Upon the Verbal Development of Imbecile Children--Part I*, 3 J. Mental Deficiency Research 122 (1959); Lyle, *The Effect of an Institution Environment Upon the Verbal Development of Imbecile Children--Part II*, 4 J. Mental Deficiency Research 1 (1960); Lyle, *The Effect of an Institution Environment Upon the Verbal Development of Imbecile Children--Part III*, 4 J. Mental Deficiency Research 14 (1960).

[7] One author terms the process "learned helplessness" where institutionalized residents become functionally incapacitated as a result of their prolonged confinement. DeVellis, *Learned Helplessness in Institutions*, Mental Retardation, Vol. 15, No. 5, at 10 (Oct. 1977).

[8] *Halderman v. Pennhurst State School and Hospital*, 446 F. Supp. 1295, 1308 n. 40 (E.D. Pa. 1977).

farms, gardens and playgrounds, the real existence behind institutional walls is one of hopelessness, helplessness and abuse.[9] No matter what rationales are employed to support the concept of segregation, the truth is that this segregation sets mentally retarded persons apart from their family, friends and community, reinforcing a prejudicial societal view of these individuals as "devalued" members of society.[10]

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[9] *See* Blatt, Exodus From Pandemonium: Human Abuse and a Reformation of Public Policy 79-80 (1970). *See generally* Herr, *Civil Rights, Uncivil Asylums and the Retarded*, 43 Cinn. L. Rev. 679 (1974); Rivera, Willowbrook: A Report on How It Is and Why It Doesn't Have To Be That Way (1972); Blatt and Kaplan, Christmas in Purgatory: A Photographic Essay on Mental Retardation (1966); Goffman, Asylums (1961). As Congress recognized during the genesis of the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §6000 et seq. (hereinafter D.D. Act), "for the vast majority of individuals institutional care is inappropriate and inhumane." H.R. Rep. 58, 94th Cong., 1st Sess. 15, reprinted in [1975] U.S. Code Cong. & Admin. News 933.

[10] *See* Dybwad and Herr, *Unnecessary Coercion: An End to Involuntary Civil Commitment of Retarded Persons*, 31 Stan. L. Rev. 753, 756 (1979). Congress has come to the realization that the fact of institutionalization creates "myths and stereotypes" which "have isolated too many individuals with learning disabilities for too long." 121 Cong. Rec. 9978 (April 10, 1975) (remarks of Cong. Schroeder). *See also* remarks of Sen. Schweiker:

> Too often developmentally disabled persons are "put away" in an institution and forgotten. It is now time to provide alternatives to locking persons up in institutions.

121 Cong. Rec. 16,522 (June 2, 1975). The House and Senate reports consistently echo these findings.

> (T)he Committee is well aware that current theory with regard to the treatment and support of the developmentally disabled emphasizes that this treatment should be conducted in the individual's community without unnecessarily institutionalizing him....

H.R. Rep. 58, 94th Cong., 1st Sess. 10, reprinted in [1975] U.S. Code Cong. & Admin. News 919, 928. In S. Rep. No. 160, 94th Cong., 1st Sess. 26-34, entitled "Forces Behind Institutionalization and

The inevitable results of segregation are most strikingly illustrated by the findings made by courts in numerous institutional cases.[11] It is true that community living arrangements, still in relatively early stages of development, have been criticized in some instances as not appropriately meeting the needs of individuals. But these deficiencies do not compare with the stark horrors of life in institutions which remain after a century of operations.[12] The beatings, mistreatment and abuse have been extensively documented.[13] Unfortunately, these conditions

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Deinstitutionalization," summarizing two years of Congressional hearings, the clear indication is that Congress in the D.D. Act desired to remedy "the rejection and exclusion from the mainstream of society" of retarded persons. *Id.* at 27.

[11] *See Michigan Association for Retarded Citizens v. Smith*, 475 F. Supp. 990 (E.D. Mich. 1979); *Iasimone v. Garrahy*, Civ. No. 77-0727 (D.R.I., April 6, 1979); *Brewster v. Dukakis*, No. 76-4423-F (D. Mass., Dec. 6, 1978); *Wuori v. Zitnay*, Civ. No. 75-80-5D (D. Me., July 14, 1978); *Evans v. Washington*, 459 F. Supp. 483 (D.D.C. 1978); *Gary W. v. Louisiana*, 437 F. Supp. 1209 (E.D. La. 1976); *Davis v. Watkins*, 384 F. Supp. 1196 (N.D. Ohio 1974) and 461 F. Supp. 842 (N.D. Ohio 1978); *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974), *aff'd in part, remanded in part*, 550 F.2d 1122 (8th Cir. 1977); *New York State Association for Retarded Children v. Rockefeller (Carey)*, 357 F. Supp. 752 (E.D.N.Y. 1973) and 393 F. Supp. 715 (E.D.N.Y. 1975); *Horacek v. Exon*, 357 F. Supp. 71 (D. Neb. 1973) and No. 72-6-299 (D. Neb. 1975); *Wyatt v. Stickney*, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub. nom. Wyatt v. Aderholt*, 503 F. 2d 1305 (5th Cir. 1974).

[12] *See* 121 Cong. Rec. 16,516 (June 2, 1975) (remarks of Sen. Williams). Among the specific abuses of which Congress was aware are:

> inappropriate admissions because of lack of community services, inappropriate and inhumane experimentation with residents, sterilizations and other operations performed for convenience of treatment, starvation and malnutrition, abuse and physical punishment, inadequate food and living conditions, and death.

Id. at 16,517. In contrast, where community facilities have had time to fully develop, as discussed in Part II.B., *infra*, the situation is unquestionably far superior to institutional operations.

[13] Thrasher, *Right to Treatment Litigation*, in Shaping the Future: Community-Based Residential Services and Facilities for Mentally Retarded People 95, 104 (Roos, McCann & Addison, eds. 1980).

have been uncovered not just in a few isolated places such as Pennhurst but in virtually every case filed in court, covering scores of states.[14]

B. The Past Rationales In Support Of Institutionalization, Based Upon Segregation Of The Mentally Retarded From Society, Are Grossly Inaccurate And Without Merit.

Today there are over 150,000 residents of public institutions for the mentally retarded.[15] Historically, these large, isolated institutions developed not as a service to aid the mentally retarded but as part of a generalized pattern of segregating the "deviant."[16] History is replete with the harshness of the treatment of "deviant" mentally retarded persons.[17]

Though mental defect has long been distingushed from mental illness and insanity,[18] the history of segregated

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[14] Congress has recognized that "such abuses are too commonplace to point at a single institution, or a single abuse, and say that it is an anomaly." 121 Cong. Rec. 16,516 (June 2, 1975) (remarks of Sen. Williams).

[15] Comptroller General of the United States, Report to the Congress, Returning the Mentally Disabled to the Community: Government Needs To Do More 9 (1977). The population peaked in 1967 at 193,200.

[16] Wolfensberger, *The Origin and Nature of Our Institutional Models*, reprinted from President's Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded (Kugel & Wolfensberger, eds. 1969). For historical trends in the institutionalization of mentally retarded persons, *see* President's Committee on Mental Retardation, Mental Retardation: Past and Present 3-23 (Gray, ed. 1976); Adams, Mental Retardation and Its Social Dimensions 16-51 (1971); Kanner, A History of the Care and Study of the Mentally Retarded (1964); Sloan, *Four Score and Seven*, 68 Am. J. Ment. Defic. 6 (1963); Haskell, *Mental Deficiency Over A Hundred Years*, 100 Am. J. Psychiat. 107 (1944).

[17] Penrose, The Biology of Mental Defect 2-3 (1966).

[18] *Id.* at 4.

confinement of mentally retarded persons is closely linked to the confinement of the insane and of the criminal.[19]

There was one historical thrust to move away from this model, yet it was rejected. Based upon an 1846 survey by Dr. Samuel Gridley Howe and his belief that mentally retarded persons could be improved in their functioning through education, Massachusetts established the first public residential institution.[20] Similar facilities, located in the hearts of communities, were established for "deviant" persons between 1850 and 1860[21] so that "expert and intensive attention could be concentrated on them."[22] Howe believed in the principle of "separation and diffusion" of the mentally retarded throughout society and, uncannily, recognized the dangers in the establishment of large, isolated, custodial institutions.

> Now the danger of misdirection . . . is, that two false principles may be incorporated with the projected institutions which will be as rotten piles in the foundations and make the future establishments deplorably defective and mischievous. These are: first, close congregation; and, second, the life-long association of a large number of idiots; whereas, the true, sound principles are: separation of idiots from each other; and then diffusion among the normal population . . . For these and other reasons it is unwise to organize establishments for teaching and training idiotic children, upon such principles as will make them become asylums for life.[23]

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[19] Rothman, *Reaction Comment*, in President's Committee on Mental Retardation, The Mentally Retarded Citizen and the Law 407, 408 (Kindred, ed. 1976).

[20] Mental Retardation: Past and Present, *supra* note 16, at 3.

[21] *Id.* at 4.

[22] Wolfensberger, *supra* note 16, at 31.

[23] Howe, *Final Report of the Superintendent to the Trustees of the Massachusetts School for Idiotic Children* (1847), cited in Mental Retardation: Past and Present, *supra* note 16, at 5.

Unfortunately, this initial thrust, similar to educational boarding schools,[24] quickly faded as society solidified its view of the mentally retarded as deviants. Since mentally retarded persons were not quickly "cured" and returned to independent community life, society shifted to a belief that the only solution to this group's limitations was to protect them from society through a system of custodial care.[25]

Developments during the early decades of this century established the foundations for institutions as they exist today. Beyond regarding the mentally retarded as "deviants," the public began to treat mental retardation as a "social menace," and the emphasis shifted to the protection of society from them.[26]

Several factors contributed to this view. First, standardized tests of intelligence were developed; testing revealed that there were more mentally retarded persons in society than previously had been recognized.[27] Second, studies of family histories suggested that mental retardation might be hereditary.[28] Third, mental retardation came to be associated with juvenile delinquency, crime, and other social evils.[29] Fourth, it was believed that the rate of reproduction of retarded persons was greater than that of non-retarded persons.[30]

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[24] Robinson & Robinson, The Mentally Retarded Child 433 (2d ed. 1976).

[25] Menolascino, Challenges in Mental Retardation 46-47 (1977).

[26] Wolfensberger, *supra* note 16, at 45.

[27] *Id.* at 46; Menolascino, *supra* note 25, at 48; Adams, *supra* note 16, at 30.

[28] Goddard, The Kallikak Family 117 (1912); Fernald, *The Burden of Feeble-Mindedness*, 17 J. Psycho-Asthenics 87 (1912); Adams, *supra* note 16, at 30-31.

[29] Wolfensberger, *supra* note 16, at 46; Adams, *supra* note 16, at 30. *See also* Bullard, *State Care of High-Grade Imbecile Girls*, Proc. Nat. Conf. Charities & Corrections 299 (1910).

[30] Wolfensberger, *supra* note 16, at 47; Menolascino, *supra* note 25, at 49.

The societal response was simple--something must be done to halt this spread of "defective persons." Obviously, the most extreme alternative was euthanasia.[31] Less drastic alternatives which would reduce the presence of mentally retarded persons in society were sterilization and institutionalization. The former was extensively employed in a misguided effort to prevent the further procreation of mental "defectives."[32] The latter, however, was an even better alternative, with the effect of segregating mentally retarded persons from society and from the possibility of procreation. Ringing with phrases such as "cutting off from the human population the supply of defectives," investigatory committees concluded that segregation was "the most practicable and acceptable means of control."[33]

While this eugenics movement also was aimed at blacks,[34] minority racial groups,[35] Mexicans and Indians,[36] and the foreign born (especially Southern Europeans)[37] and did affect the formulation of attitudes and policies,[38] the long-range effects fell most devastatingly on the mentally retarded. The most far-reaching harm

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[31] While not utilized as a realistic alternative in the United States, euthanasia became widely utilized in Nazi Germany. *See* Penrose, *supra* note 17, at 2.

[32] *See* Chase, The Legacy of Malthus (1977). *See also* Burgdorf & Burgdorf, *The Wicked Witch Is Almost Dead: Buck v. Bell and the Sterilization of Handicapped Persons*, 50 Temp. L.Q. 995 (1977).

[33] Davies, Social Control of the Mentally Deficient 121 (1930).

[34] Galton, Hereditary Genius: An Inquiry Into Its Law and Consequences 393-96 (1869).

[35] Pickens, Eugenics and Progressives 57 (1968).

[36] Popenoe & Johnson, Applied Eugenics 283 (1933).

[37] Whitney, The Case for Sterilization 147-49 (1934); Popenoe & Johnson, *supra* note 36, at 291; Pickens, *supra* note 35, at 65-67.

[38] Pickens, *supra* note 35, at 66. *See generally* Sarason & Doris, Psychological Problems in Mental Deficiency 310-11 (1969).

> lay in the philosophical rationale underlying the pattern of services and its acceptance by society as a whole. It contributed to the social devaluation of the retarded as human beings, and to their psychological and physical alienation from society, and singled them out on a fundamentally negative basis in a way that no other group has experienced since the quaranteening of lepers in the middle ages.[39]

Despite the harms of such a policy of segregation and the harms related to providing merely custodial care without education or training, the overriding purpose of institutionalization remained unquestioned.

> The objection may be urged that lifelong "confinement in an institution would suppress individuality and initiative [and] transform the inmates into unthinking mechanical automatons (robots)...[S]uch difficulties of adjustment when found would constitute a lesser evil than permitting mental deficients to enjoy unrestricted conjugal relations in society...In spite of its hampering limitations, at the present time segregation is probably the most feasible and the least objectionable means of checking the multiplication of dysgenic stocks.[40]

Long after these rationales for segregation had faded or had been discredited[41] and long after it was recognized that the goals of segregation could not be met,[42] institutions

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[39] Adams, *supra* note 16, at 32.

[40] Wallin, Mental Deficiency 159 (1956).

[41] Fernald, *State Programs for the Care of the Mentally Defective*, 24 J. Psycho-Asthenics 114, 119-20 (1919). Current accepted attitudes toward mental retardation are expressed in the concepts of normalization, habilitation, and the developmental model. *See* Wolfensberger, The Principle of Normalization in Human Services (1972); Mason & Menolascino, *The Right to Treatment For Mentally Retarded Citizens: An Evolving Interface*, 10 Creighton L. Rev. 124 (1976); Roos, *Basic Facts About Mental Retardation*, 1 Legal Rights of the Mentally Handicapped 17 (Ennis & Friedman, eds. 1973).

[42] Davies, *supra* note 33, at 130.

continued to exist and to grow. Confinement of the mentally retarded had in the twentieth century become a well-established "social institution." Society was also unwilling to abandon its substantial investment in buildings and land, and society, further, had failed to provide community alternatives.[43] Not until the federal government began to legislate in this area and the federal courts began to scrutinize the faulty rationales behind the existence of these institutional settings did this old segregation model begin to fade.[44] However, new rationales have recently been developed, equally discriminatory, which threaten to undermine this growth away from unnecessary segregation (*See* Section II.B., *infra*).

II. THE CURRENT RATIONALES IN SUPPORT OF SEGREGATION OF THE MENTALLY RETARDED ARE PREJUDICIAL AND INVALID BECAUSE THEY IGNORE THE SUBSTANTIAL DATA WHICH EXIST ON SUCCESSFUL HABILITATIONAL AND COMMUNITY PROGRAMS.

Recently, the justification for segregating the mentally retarded from society has shifted back to a protective rationale, strikingly similar to that of an earlier era. This current protective rationale rests upon the assumptions that there are a class of mentally retarded persons, especially severely and profoundly retarded persons, who cannot benefit from habilitation and will never be able to live outside the "safe" institution. *Amici* submit that these assertions merely restate earlier prejudicial views of the mentally retarded. In the following sections, *amici* will place the issue in its proper perspective, and then discuss data which directly refute these rationales for segregation.

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[43] Wolfensberger, *supra* note 16, at 77-78.

[44] The briefs of appellees support and discuss this point fully.

A. Mental Retardation Is A Developmental Disability Necessitating The Provision Of Education And Training.

The Court need not concern itself with "the baffling field of psychiatry,"[45] as this case concerns the habilitation of mentally retarded individuals.[46] The most widely used definition of mental retardation is that adopted by the American Association on Mental Deficiency:

> Mental retardation refers to significantly subaverage intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested in the developmental period.[47]

Mentally retarded persons are not ill, needing treatment; rather, they are uneducated and untrained.[48] In fact, the major difference between a mentally retarded child and any other child is the mentally retarded child's inability to recognize cues and stimuli from his surroundings as appropriate guides to behavior.[49]

What is needed by the mentally retarded individual is a process of habilitation.

> [T]he overall thrust of modern habilitation is the remediation of the delayed learning process so as to develop the maximum growth potential by the acquisition of self-help, language, personal, social, educational, vocational, and recreational skills.[50]

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[45] *O'Connor v. Donaldson*, 422 U.S. 575, 578 n. 2 (Burger, C.J., concurring).

[46] Mental retardation is included within the scope of the definition of developmental disabilities. D.D. Act, 42 U.S.C. §6001 (7)(A)(i); *Halderman v. Pennhurst State School & Hospital*, 612 F. 2d. 84, 95 (3rd Cir. 1979).

[47] Grossman, Manual of Terminology and Classification in Mental Retardation (1973).

[48] Leland & Smith, Mental Retardation: Present and Future Perspectives 80 (1974).

[49] *Id.* at 6.

[50] Mason & Menolascino, *supra* note 41, at 139-40.

The key to meeting the needs of the mentally retarded person is to improve his *learning* process.[51] In other words, *education*, in a sense broader than traditional schooling, is the critical service which society must provide.[52] Without educational services, the individual will be doomed to the limitations imposed by his/her own intellectual and functional deficiencies.

This Court long ago recognized the significance of education, including the harms resulting from segregating persons for the purpose of education.

> Today education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditure for education both demonstrate our recognition of the importance of education to our democratic society...In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education...Separate educational facilities are inherently unequal.

Brown v. Board of Education, 347 U.S. 483, 492 (1954). Data relied upon by the Court in *Brown* as well as data relied upon by the court in *Pennsylvania Association for Retarded Children v. Commonwealth of Pennsylvania*, 334 F. Supp. 1257 (E.D. Pa. 1971), guaranteeing mentally retarded children a similar right to education, reflect that education is viewed as a broad term. Education must be seen as a "continuous process by which individuals learn to cope and function within their environment,"[53] as part of a

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[51] The Court of Appeals below recognized that there is broad potential for "remediation of the delayed learning process" in mentally retarded persons. 612 F.2d at 93.

[52] The district court below recognized, based upon the expert testimony it received, that "mental retardation is primarily an educational problem." 446 F. Supp. at 1298.

[53] Weintraub & Abeson, *New Education Policies For the Handicapped: The Quiet Revolution*, in Public Policy and the Education of Exceptional Children 78 (Weintraub, Abeson, Ballard & Lavor, eds. 1976).

much larger social context.[54] Furthermore, whether the process is called education or training is not relevant since the goal is the same--to improve the individual's functioning and capabilities.[55]

The importance of the education process for all mentally retarded persons cannot be overstated. It has repeatedly been shown that

> retarded children of any intelligence quotient are capable of benefiting from education... Education is even more important to the development of the retarded citizen than it is to normal citizens, for the latter may develop skills willy-nilly and informally, but the retarded citizen cannot, without sustained educational attention.[56]

This education process is, in fact, similar to the education process utilized for all individuals,[57] best exemplified by the widespread acceptance of the Montessori system of education.[58] This education approach developed from the conclusion that the problem of mental deficiency was essentially educational and not medical.[59]

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[54] Blatt, Bogdan, Biklen & Taylor, *From Institution to Community: A Conversion Model*, in Educational Programming for the Severely and Profoundly Handicapped 40 (Sontag, ed. 1977).

[55] Whelan, *We've Only Just Begun*, in Educational Programming for the Severely and Profoundly Handicapped 469 (Sontag, ed. 1977).

[56] Lippman & Goldberg, Right to Education: Anatomy of the Pennsylvania Case and Its Implications for Exceptional Children (1973), cited in Robinson & Robinson, *supra* note 24, at 364. The practical experience of the Nebraska Community-based Mental Retardation programs confirms this. *See* note 108, *infra*, and accompanying text.

[57] Davies, *supra* note 33, at 43.

[58] *Id.*

[59] Robinson & Robinson, *supra* note 24, at 366. While the causes of mental retardation may, in some instances, be medical, the process of remediation is clearly educational and habilitational.

Furthermore, educators have stressed the potential harm associated with isolating handicapped children from a regular educational environment.

> Since the turn of the century, public schools have practiced segregating handicapped children into special classes for instruction...Now upon learning of the potentially dehumanizing effect of categorizing and segregating handicapped children in education, regular education is faced with the need for changes that will provide appropriate education in the mainsteam. Similarly, special education is faced with redefining its role of being a resource to these children in the mainstream without excessive characterization and "pull-out" programs.[60]

The family and home life and upbringing of an individual is also a key component of his/her educational process. The Court has repeatedly emphasized the value of family life in its recognition of the rearing of children as a fundamental right.[61] From an educational perspective, the family provides the basic socialization process. The prevalent socio-cultural attitudes and values in the United States rest upon keeping a child at home and maintaining the family.[62] *Amici* submit that even a clean and safe

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[60] Miller & Miller, *The Handicapped Child's Civil Right As It Relates to the "Least Restrictive Environment" and Appropriate Mainstreaming*, 54 Ind. L.J. 1, 7 (1978); *See also* Note, *Enforcing the Right to an "Appropriate" Education: The Education for All Handicapped Children Act of 1975*, 92 Harv. L. Rev. 1103, 1119-20 (1974).

[61] *See e.g. Smith v. Organization of Foster Families for Equality and Reform*, 431 U.S. 816 (1977); *Moore v. City of East Cleveland, Ohio*, 431 U.S. 494 (1977); *Roe v. Wade*, 410 U.S. 113 (1973); *Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

[62] Wolfensberger, *Will There Always Be an Institution? II: The Impact of New Service Models*, in The History Of Mental Retardation Vol. II, 415, 429 (Rosen, Clark & Kurtz, eds. 1976).

institution cannot provided needed socialization and human activities; rather, it necessarily provides a degenerative and depersonalizing environment.[63] As the authors of a basic textbook in mental retardation conclude:

> Institutionalization is contrary to the American value system...The family is viewed as a primary socializing agent, and the removal of a member of the family to an institution means that the individual will cease to function as a sociological member of the family.[64]

The school in this process ranks second only to the home in its impact on and development of essential societal skills.[65]

Statistics illustrate that most mentally retarded persons at the time of admission to an institution are still children and, in fact, the percentage of those being admitted who are children has been increasing.[66] In addition, the average age of the residents presently in institutions has been rapidly decreasing, so that by 1970 over half of the residents were under the age of 19.[67] *Amici* submit that this Court, as did the Court below, must focus upon the individual needs of each resident, which, it is apparent, rest heavily upon his or her learning and educational needs. Furthermore, the Court should recognize that appellees are not attempting to interfere in the intimate affairs of families; rather, the individualized approach advanced by appellees, and found by the court below to be appropriate, attempts to

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[63] *See* Leland & Smith, *supra* note 48, at 82.

[64] Chinn, Drew & Logan, Mental Retardation: A Life Cycle Approach (2d ed. 1979).

[65] Robinson & Robinson, *supra* note 24, at 365.

[66] *Id.* at 435. In 1950, 79% of persons admitted to mental retardation institutions were under the age of 19 while by 1970 this percentage had risen to 87.5%.

[67] *Id.* While in 1950, only 32.7% of the resident population of institutions for the mentally retarded were under the age of 19, by 1970 this percentage had increased to 50.4%.

strengthen and maintain the traditional American belief in families by ensuring, where appropriate, the maintenance of community ties and family involvement.

B. Existing Data Illustrate The Fact That All Mentally Retarded Persons, Including Severely And Profoundly Retarded Persons, Are Capable Of Benefiting From Education And Training And That Habilitation Services Can Successfully Be Provided In Non-Segregated Community Settings.

1. *Severely and Profoundly Mentally Retarded Persons Can Benefit From Education and Training Services.* Despite the attempt in this case by some *amici* groups to portray severely and profoundly mentally retarded persons as incapable of benefiting from education and training services and incapable of residing in the community without grave danger, the expert data simply do not support this highly prejudicial and misconceived view. Rather, the arguments raised by these *amici* groups in support of the maintenance of segregation sound disturbingly similar to the kinds of arguments and warnings of pending harms and danger raised to oppose the desegregation of public schools mandated by this Court in *Brown v. Board of Education*, 347 U.S. 483 (1954).[68]

In the past two decades there has been a radical change in the view of professionals regarding the developmental potential of severely and profoundly retarded individuals.

> By the 1970's there was a large scientific literature documenting the behavioral potential of severely-profoundly retarded persons. A previous emphasis on diagnosis and classification has shifted to an experimental orientation. New methods for assessing and observing the behavior of previously "untestable" individuals were developed. The importance of the environment and of adequate stimulation was

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[68] *See generally* Kluger, Simple Justice (1976).

> confirmed repeatedly, and basic principles of learning were used to increase self-help, social, academic, and vocational skills of severely-profoundly retarded persons.[69]

The effectiveness of the behavioral techniques which have been employed by professionals has been well documented.[70] There is extensive documentation of the increased independence of severely and profoundly retarded persons in the areas of self-help skills,[71] reduction of undesirable behaviors,[72] language skills,[73] social skills,[74]

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[69] Berkson & Landesman-Dwyer, *Behavioral Research on Severe and Profound Mental Retardation*, 81 Am. J. Ment. Defic. 428 (1977).

[70] *Id.* at 432. For an exhaustive documentation of studies supporting the data presented herein, *see* NCLH monograph, Recent Developments in Right to Treatment and Deinstitutionalization Cases (1979), reprinted in Amicus, Vol. 5, No. 2 (March-April 1980).

[71] *See e.g.* O'Brien, Agrin & Boyle, *Training Profoundly Retarded Children to Stop Crawling*, 5 J.A.B.A. 131 (1972) (walking); Osarchuk, *Operant Methods of Toilet Training of Severely and Profoundly Retarded: A Review*, 7 J. of Spec. Ed. 423 (1973) (proper toileting); Martin, Kehoe, Bird, Jensen & Darbyshire, *Operant Conditioning in Dressing Behavior of Severely Retarded Girls*, Mental Retardation, Vol. 9, No. 3, at 27 (June 1971) (dressing themselves). Other self-help skills documented include self-feeding, standing without support, brushing teeth, and self-medication.

[72] *See e.g.* Murphy, Nuner & Hutchings-Ruprecht, *Reduction of Stereotyped Behavior in Profoundly Retarded Individuals*, 82 Am. J. Ment. Defic. 238 (1977) (reducing stereotyped behaviors); Rapp & Deitz, *Reducing Aggressive and Self-Injurious Behaviors of Institutionalized Retarded Children Through Reinforcement of Other Behaviors*, 7 J.A.B.A. 313 (1974) (reducing antisocial and self-abusive behaviors).

[73] *See e.g.* Booth, *Early Receptive Language Training for the Severely and Profoundly Retarded*, Language, Speech, and Hearing Services in the Schools, Vol. 9, No. 3, at 151 (July 1978) (general language skills); Barrett & McCormack, *Varied-Teaching Tutorials: A Tactic for Generating Credible Skills in Severely Retarded People*, Mental Retardation, Vol. II, No. 6, at 14 (Dec. 1973) (primitive reading skills). Other language skills include learning picture names, asking

and vocational skills.[75] The important factor in achieving these successful results is the *program* employed.

> A number of the traditional assumptions underlying instructional programs for severely handicapped children have been challenged by those who believe that acquisition of skills may be more a function of instructional programming than a question of limited mental ability...A crucial difference in the teaching procedures utilized with the severely handicapped, as differentiated from the normal or the mildly handicapped, is the degree of precision required in instructional programming...As a result, the disciplined precision required by a task-analysis approach to instructional programming has been

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questions, developing snytax, responding to greetings, and following instructions.

[74] Williams & Hamre-Nietupski, *Teaching Selected Social Skills to Severely Handicapped Students*, SALT: School Applications of Learning Theory, Vol. 8, No. 3, at 1 (April 1976) (eliciting social responses); Altman, Cleland & Swartz, *Social Responsibility in the Profoundly Mentally Retarded*, 34 Perceptual and Motor Skills 101 (1972) (acquisition of hand-shake greetings); Hooper & Wambold, *Improving the Independent Play of Severely Retarded Children*, Educ. and Train. of the Ment. Retarded, Vol. 13, No. 1, at 42 (Feb. 1978) (cooperative play). Other social skills include child-initiated face-to-face orientation with others and child-initiated non-aggressive physical contact involving the hands with others.

[75] *See e.g.* Bellamy, Peterson & Close, *Habilitation of the Severely and Profoundly Retarded: Illustrations of Competence*, 10 Ed. and Training of the Mentally Retarded 1974 (1975) (general vocational tasks); Gold, *Task Analysis of a Complex Assembly Task by the Retarded Blind*, Exceptional Children, Vol. 43, No. 2, at 78 (Oct. 1976) (complex vocational tasks); O'Neill & Bellamy, *Evaluation of a Procedure for Teaching Saw Chain Assembly to a Severely Retarded Woman*, Mental Retardation, Vol. 16, No. 1, at 37 (Feb. 1978) (concluding that even severe retardation does not restrict an individual's potential to learn a variety of work behaviors and that the training procedure is the key not the degree of retardation.

relied upon in an increasing number of successful educational programs for the severely handicapped.[76]

Furthermore, these programs can be successfully carried out in various environments and by professionals or non-professionals.[77] Thus, educational and training programs for severely and profoundly mentally retarded persons have been shown not only to be successful but also to be feasible in a variety of settings provided that *appropriate* programming techniques are utilized.[78]

2. *Recent Studies Illustrate That Virtually All Mentally Retarded Persons, Including Severely and Profoundly Retarded Persons, Can Successfully Reside in the Community with the Provision of Appropriate Services.* *Amici* groups in support of appellants also have attempted to convince this Court that most severely and profoundly retarded individuals will never be able to reside in the community, by discussing the problems of specific instances of inappropriate community living arrangements and then generalizing these deficiencies to apply to the situations of all individuals labeled as severely or profoundly retarded. However, they fail to understand their own basic point; it is the inadequacy of the services in those residences that is to blame, not the inadequacy of the

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[76] Sontag, Dodd & Button, *The Education and Community Support of Severely Handicapped People*, 6 Int. J. Ment. Health 35, 36 (1977). In this sense, program means the individual habilitation program.

[77] *See* Gladstone & Sherman, *Developing Generalized Behavior-Modification Skills in High-School Students Working With Retarded Children*, 8 J.A.B.A. 169 (1975); Phillips, Leibert & Poulos, *Exploring Paraprofessional Teachers in a Group Language Training Program for Severely and Profoundly Retarded Children*, 36 Perceptual and Motor Skills 607 (1973); Fabry & Reid, *Teaching Foster Grandparents to Train Severely Handicapped Persons*, 11 J.A.B.A. 111 (1978).

[78] *See* Bronston, *Matter of Design*, in Toward Excellence: Achievements in Residential Services for Persons with Disabilities 7, 14 (Apolloni, Cappuccilli & Cooke, eds. 1980), emphasizing program and not the dwelling as the key to successful community placement.

mentally retarded residents. The data illustrate clearly that no single variable is a reliable predictor of successful community adjustment.[79] The majority of studies have found no meaningful relationships between I.Q. and successful community placement.[80]

The important factor is what the Third Circuit below relied upon in interpreting Congressional intent--the special, individualized needs of each mentally retarded person. There is no question but that there are important differences in quality of care given by different community facilities.[81] Where appropriate care is provided and appropriate placement occurs, risks are minimized.[82]

Numerous studies illustrate the diversity of activities available to profoundly and severely retarded persons living in appropriate community settings, the successful adaption to community placement, and the level of satisfaction evidenced by both the former institutional residents and their new "families."[83] A recent comprehensive

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[79] McCarver & Craig, *Placement of the Retarded in the Community: Prognosis and Outcome*, in 7 Int. Review of Research in Mental Retardation 145, 168-78 (Ellis, ed. 1974).

[80] *Id.* at 170-72. Again this fact is clearly supported by the reality of existing successful community service systems. *See e.g.* note 108, *infra*, and accompanying text for the experience in Nebraska.

[81] Butterfield, *Institutionalization and Its Alternatives for Mentally Retarded People in the United States*, 6 Int. J. Ment. Health 21 (1977); Bjaanes & Butler, *Environmental Variation in Community Care Facilities for Mentally Retarded Persons*, 78 Am. J. Ment. Defic. 429 (1974).

[82] Nihira & Nihira, *Jeopardy in Community Placement*, 79 Am. J. Ment. Defic. 538 (1975); Nihira & Nihira, *Normalized Behavior in Community Placement*, Mental Retardation, Vol. 13, No. 2, at 9 (April 1975); Retish, Hey & Boaz, *Systems Unlimited-Normalization Exemplified*, Mental Retardation, Vol. 16, No. 4, at 313 (Aug. 1978).

[83] Gollay, Friedman, Wyngaarden & Kurtz, *Coming Back: The Community Experiences of Deinstitutionalized Mentally Retarded People* (1978) (contrary to the assertions in the brief of *amici*,

review of studies has led, once again, to the conclusion that level of retardation cannot be simply and directly correlated with successful community placement.

> [S]ome recent data support the assertion that there are cost-efficient, community based, culturally normative alternatives..., that large numbers of individuals have been placed in them over the past 10 years. Success of placement was seen to depend primarily on the quality of the community support system rather than on characteristics of individuals themselves... There appears to be very little empirical support for restricting placement on the basis of age or IQ, except that demands for community service and environmental supports appear to correlate with these variables.[84]

Heavily represented among *amici* groups in support of appellants are Nebraska parties.[85] These groups all continue to support the segregation of mentally retarded persons in institutions, especially severely retarded persons. Yet an examination of data from Nebraska provides a strikingly different picture from that presented by these *amici* groups.

Congress of Advocates for the Retarded, approximately 25% of the study group consisted of severely or profoundly retarded individuals); Nihira & Nihira, *supra* note 82; Close, *Community Living for Severely and Profoundly Retarded Adults: A Group Home Study*, Educ. and Train. of the Ment. Retarded, Vol. 12, No. 3, at 256 (Oct. 1977). *See generally* Sontag, Certo & Button, *On a Distinction Between the Education of the Severely and Profoundly Handicapped and a Doctrine of Limitations*, Exceptional Children, Vol. 45, No. 8, at 604 (May 1979).

[84] Heal, Sigelman & Switsky, *Research on Community Residential Alternatives for the Mentally Retarded*, in 9 Int. Review of Research in Mental Retardation 209, 243 (Ellis, ed. 1978). *See also* Bell, *IQ As A Factor in Community Life Style of Previously Institutionalized Retardates*, Mental Retardation, Vol. 14, No. 3, at 29 (1976).

[85] The Beatrice State Developmental Center has been the focus of litigation and implementation of a consent decree entered into in 1975. *Horacek v. Exon*, 357 F. Supp. 71 (D. Neb. 1973) and No. 72-6-299 (D. Neb. 1975).

Over twenty-five percent of all mentally retarded persons being served in Nebraska Community-based Mental Retardation programs (CBMRs) are severely and profoundly retarded.[86] Despite the assertion that many residents of Pennhurst cannot be served due to their mobility problems, the Nebraska CBMRs serve 139 (5%) clients who are non-ambulatory (not mobile without assistance or without prosthetic devices) and 163 (6%) clients who are mobile/non-ambulatory (able to move without assistance only if a barrier-free environment exists).[87] Furthermore, the CBMRs serve 355 clients with behavior disorders serious enough to require special intervention and intensive behavioral programming.[88]

The stability of these community settings has been firmly established, and the continuity of this system of community programs remains unquestioned.[89] Under scrutiny by accreditation agencies as to the quality of the programs, the community settings have fared much better than the institutional setting.[90] Their success rate is evidenced by

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[86] Regional Directors' Council, Nebraska Community-based Mental Retardation Programs: Three Year Plan 1979-1982 at 125 (1980) (508 severe and profound and 1446 mild and moderate).

[87] *Id.* at 127-128.

[88] *Id.* at 130.

[89] *Id.* at 21-24. The state does not operate the CBMRs, rather the 6 regional programs are under the operational control of local subdivisions of government and have functioned since the 1972-73 fiscal year. The CBMRs do, however, receive substantial state funding and are subject to state standards.

[90] *See* Sales & Frohboese, *Parental Opposition to Deinstitutionalization: A Challenge in Need of Attention and Resolution*, Law and Human Behavior, Vol. 4, Nos. 1-2 (1980) [adapted from an unpublished dissertation at University of Nebraska-Lincoln at 112 (Dec. 1979)], noting that Beatrice State Developmental Center is not accredited while five of the six CBMRs have been accredited by the Joint Commission on Accreditation of Hospitals.

the fact that from fiscal year 1968-69 through 1972-73, when the CBMRs were created, 25% of placements out of the institution were into the community while 40% were into nursing homes; since 1972-73, 74.4% of placements have been into the community while only 7.2% have been into nursing homes.[91] Since 1972-73, while 479 individuals have been placed from the institution into the community, only 35 have been returned.[92]

The distorted picture of mentally retarded residents of Pennhurst and other institutions, presented by the *amici* brief of the Congress of Advocates For the Retarded, is one of non-functioning, medically dependent individuals, who could not survive but for the protective institutional environment. In a study commissioned by the Nebraska Department of Public Welfare and Department of Public Institutions, Touche Ross & Co. reported that

> of the approximately 335 BSDC (Beatrice State Development Center) clients identified with special medical needs, in the *opinion of the BSDC medical staff* only 8 require intense medical services not typically provided in the CBMR residential programs.[93]

Furthermore, Touche Ross & Co. found that the remaining 327 clients with special medical needs could be appropriately served in CBMR programs with special support.[94] In addition, Touche Ross & Co. found that the

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[91] Three Year Plan, *supra* note 86, at 23.

[92] *Id.* This total of 35 represents a duplicated count, meaning that each time a single individual returns to an institution, he/she is again counted as a readmission. Thus, the actual number of individuals who have returned to the institution could be much less.

[93] Touche Ross & Co., State of Nebraska: Cost Study of the Community Based Mental Retardation Regions and the Beatrice State Developmental Center 41 (August 15, 1980) (emphasis added).

[94] *See id.* at 85-86 (Schedule 30), for a detailed description of the medical conditions and how the CBMRs would service those needs.

CBMRs were already serving numerous clients with high or moderate needs and that to provide a full range of services would cost the same or significantly less than the cost of services in the institution.[95]

Serving severely and profoundly retarded individuals in the community is not unique to Nebraska and certainly is not the "impossibility" suggested by the *amici* groups supporting appellants. In the Macomb-Oakland Regional Center program in Michigan, for example, which is a component of the state system of mental retardation services, sixty percent (60%) of persons served in group homes and community training homes have severe to profound mental retardation.[96] Of these individuals, seventy percent (70%) have serious secondary handicaps,[97] and many are considered medically fragile.[98]

A national survey found that as of June 30, 1977, thirty-two percent (32%) of all residents of community facilities were severely and profoundly retarded,[99] more than half had at least one additional handicap,[100] and twenty-three and one-half percent (23.5%) of those in community facilities of ten or less residents were severely and profoundly retarded.[101] Eighty-two percent of these residents exhibited at least one limitation in functional daily living skills.[102] Furthermore, nineteen percent were

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[95] *See id.* at 23-27.

[96] Provencal, *The Macomb-Oakland Regional Center*, in Toward Excellence: Achievements in Residential Services for Persons with Disabilities 19, 25 (Apolloni, Cappuccilli & Cooke, eds. 1980).

[97] *Id.*

[98] *Id.* at 40.

[99] Bruininks, Hauber & Kudla, National Survey of Community Residential Facilities: A Profile of Facilities and Residents in 1977 at 75 (Developmental Disabilities Project on Residential Services and Community Adjustment 1979).

[100] *Id.* at 79.

[101] *Id.* at 82.

[102] *Id.* at 83-84.

multiply handicapped with two or more handicaps in addition to retardation.[103] Finally, over fifty percent of the community facilities reported no movement into or out of the facility during the twelve month period covered by the survey, illustrating a level of stability.[104] This reality contrasts with the generalizations asserted by the *amici* brief of the Congress of Advocates for the Retarded, which, rather than focusing on individual needs and programs, draws conclusions on the basis of labels.

The *amici* brief filed by Congress of Advocates for the Retarded, et al., also claims that no parties at trial raised opposition to community care for all mentally retarded persons. The reason, very simply, is that Pennsylvania recognized that the argument against the viability of community services is spurious. As acknowledged by the Director for the Bureau of Community Programs, Office of Mental Retardation, Commonwealth of Pennsylvania, the community living arrangement program, which would serve the class of persons in the case at Bar, is "structured to meet the needs of all mentally retarded individuals, no matter what the age or severity of handicap."[105] The Superintendent of Pennhurst and the regional administrators have repeatedly admitted that all residents of Pennhurst--all retarded individuals--can reside in community living arrangement programs.[106] Even those

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[103] *Id.* at 83.

[104] *Id.* at 91.

[105] Knowlton, *The Pennsylvania System*, in Toward Excellence: Achievements in Residential Services for Persons with Disabilities 127, 132 (Apolloni, Cappuccilli & Cooke, eds. 1980).

[106] The Third Circuit, 612 F.2d at 93 (1979), and the District Court, 446 F. Supp. at 1312-1313 (1977), recognized this. The record is replete with acknowledgements by state officials that *Pennhurst* should be closed and that all residents could be served in the community. *See* Youngberg deposition at 102, Foster deposition at 63, and Rice deposition at 180-81. In the transcript, *see* 22-171 to 172 (Youngberg), 22-77 (Foster) and 26-22 (Rice). The state experts at trial also agreed. *See* transcript at 14-73 (Thurman) and 14-21 (Walker).

who are medically fragile are now beginning to be served in small homes, apartments, and single-client placement sites.[107]

This data, *amici* submit, illustrate that there exists no empirical support for institutions or for segregation. Rather, these segregation policies are an extension of misguided prejudices. As the Nebraska CBMR plan verifies:

> Experience has shown that...services can be provided within community-based mental retardation programs for all of the individuals being discussed... The regions (CBMRs) are currently serving people in all IQ categories and with all levels of handicapping conditions. This demonstrates a capacity on the part of the regions to serve the entire range of mental retardation. Therefore, the ability to serve those "multiply" handicapped individuals is not the exclusive providence of the institution.[108]

CONCLUSION

The Court has before it a case involving the segregation of mentally retarded persons. But the Court need not consider this issue in a vacuum. Rather, Congress has carefully scrutinized this issue and all relevant data and has passed legislation which makes it unmistakenly clear that integration of the mentally retarded into society is the operable goal.

Over a period of years, Congress repeatedly had before it for consideration the data discussed herein. In addition, it had the findings of numerous lower courts which exposed the horrors of segregated life and upheld the rights of mentally retarded individuals to equal treatment in all aspects of society.

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[107] Knowlton, *supra* note 105, at 133, 137.

[108] Three Year Plan, *supra* note 86, at 112.

By enacting the Rehabilitation Act of 1973, 29 U.S.C. §701 et seq., Congress acted to prohibit discrimination of the handicapped generally, both by recipients of federal financial assistance, 29 U.S.C. §794, and by federal contractors of $2500 or more, 29 U.S.C. §793. In 1975, Congress passed the Education for All Handicapped Children Act, 20 U.S.C. §1401 et seq., to prohibit segregated education and to guarantee all handicapped children a right to a free, appropriate public education in an integrated environment. In 1975, the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. 6000 et seq., was passed by Congress, continuing and expanding its attempt to provide needed services to handicapped persons while ending their unnecessary segregation from society.

Rather than awaiting definitive action by this Court to rectify injustices, as it had in the racial segregation issue, Congress acted to ensure on an individualized basis that every person, whether called handicapped, developmentally disabled or mentally retarded, be free from the unwarranted exclusion from society. The Third Circuit below did nothing more than apply this concept of individualized determination in establishing a process by which mentally retarded persons could finally, as Congress intended, be returned to community life.

For the reasons discussed in this brief, *amici* respectfully request this Court to affirm the decision of the United States Court of Appeals for the Third Circuit.

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In The

SUPREME COURT OF THE UNITED STATES

October Term, 1980

Nos. 70-1404, 79-1408, 79-1414, 79-1415, and 79-1489

Pennhurst State School and Hospital, *et al*,

Petitioners,

v.

Terri Lee Halderman, *et al*,

Respondents.

On *Writ of Certiorari* to the United States Court of Appeals for the Third Circuit

Motion for leave to file brief *amici curiae* and brief for **People First International, Inc., People First of California, Inc., Mohawks and Squaws, America Coalition of Citizens with Disabilities, Inc., Center for Independent Living, Inc., Prime Movers, Inc., Center for Independence of the Disabled of New York, Inc., Washington Coalition of Citizens with Disabilities, Community Service Center for the Disabled, Inc., Holistic Approaches to Independent Living, Inc., Access Living of Metropolitan Chicago, Illinois Council, Congress of Organizations of the Physically Handicapped, Paraquad, Inc., Stavros Foundation, Coalition for Barrier Free Living, Inc., as *amici curiae***

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MOTION FOR LEAVE TO FILE BRIEF
AMICI CURIAE

People First International, Inc, (hereinafter referred to as "People First") and the organizations named in paragraph 1 hereof, move for leave to file the attached brief amici curiae.[1]

1. People First International, Inc. , People First of California, Inc. & the Mohawks & Squaws are organizations of persons who are retarded. Their interest in this case, as well as all amici, is fully explained in the "Interest of Amici" section of the attached brief. As representatives of the class of persons that will be most affected by this case, People First International and other organizations of persons who are retarded support the decisions below and the principle that all persons, regardless of their degree of disability, have the right to receive services designed to enhance, rather than retard, their capabilities.

2. The American Coalition of Citizens with Disabilities, (ACCD) as an umbrella organization representing persons of all disabilities throughout the nation, was founded on the principle that all persons with disabilities should be able to control their own lives, to the maximum extent possible, and to live in an integrated setting in their communities.

[1] All respondents have consented to the filing of this brief, and the United States has indicated that it expects to consent. Petitioners have not yet indicated whether they will consent.

3. The Center for Independent Living and other independent living centers are community-based organizations, directed and staffed by persons with disabilities. Their primary objectives are to provide services for persons with severe disabilities to enable them to live within the community, and to advocate for the rights of persons with disabilities. Because of the availability of the services from amici and other independent living centers, substantial numbers of persons with disabilities have been able to successfully move into their communities and avoid institutionalization.

4. Congress has repeatedly expressed recognition of the competence of persons with the most severe disabilities to learn and enhance their abilities, when provided with services tailored to their particular needs in the community. Congress has specifically rejected the medical model that regards persons with severe disabilities as diseased. It has accepted the developmental model, which regards severely disabled persons as individuals, capable of continual improvement.

5. Congress has also recognized that persons with disabilities are entitled to take part in decision-making processes involving their lives and to speak for themselves, to the maximum extent possible. People First International, et al., as organizations directly representing those who will be affected by the outcome of this case, believe that their experiences and views deserve to be heard. As Amici's brief demonstrates, the Court below based its opinion on clearly expressed mandates from Congress.

CONCLUSION

Amici have a substantial and direct interest in this case; they have a unique and important perspective concerning the issues before this Court. Therefore, this motion for leave to file a brief as amici curiae should be granted.

Respectfully submitted,

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For Amici

BRIEF FOR PEOPLE FIRST INTERNATIONAL, INC., et al., AMICI CURIAE

INTEREST OF THE AMICI

Amici represent three different categories of groups representing people with disabilities: People First International and other organizations of persons with retardation, the American Coalition of Citizens with Disabilities, and Independent Living Centers.

PEOPLE FIRST INTERNATIONAL AND OTHER ORGANIZATIONS OF PERSONS WITH RETARDATION

People first International Inc., was formed in 1974 and is a non-profit corporation under the laws of the state of Oregon. People First International was organized by persons who are retarded in Salem, Oregon, who felt the need for their own community support network, and it was the first organization of persons with retardation in the country.[1] People First International provides peer support services for people who are retarded and are moving from institutions into the community, and those who have resided in the community for an extended period of time. Based on the principle that persons with retardation can and should speak for themselves, People First International provides members with assistance in communicating with others, understanding social service program requirements and rules, and organizing members to advocate for transportation, housing and employment.

People First International is a full partner organization in the U.S. Council for the International Year of Disabled People. People First

[1]From MR:78, Report to the President, President's Committee on Mental Retardation: The Leading Edge, Programs that Work", p. 53:

> A gentle protest can now be heard throughout the nation from mentally retarded persons who are tired of being over-protected. They

International members are on the Boards of Directors of the National Association for Retarded Citizens, the Oregon Association for Retarded Citizens, the Oregon Developmental Disabilities Advocacy Center, the State Developmental Disabilities Council and the Governor's Committee for the Handicapped. People First International members have testified at a variety of local and state legislative bodies concerning programs, funding, zoning budget cuts, guardianship and conservatorship legislation, sterilization legislation and other issues. People First International has received requests from all 50 states and eleven foreign countries, for information.

People First of California, Inc., is a non-profit corporation incorporated under the laws of the State of California. The by-laws of People First of California state:

> Article II, Section 2: The specific and primary purposes for which this corporation (is founded) shall be to offer adults with developmental disabilities the opportunity to reach their highest possible levels of self-determination by assisting them in: (a) supporting the right of people with developmental disabilities to

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have begun to object when professionals and non-professionals make decisions for them and speak for them, when, with a little time and patience, they could have decided and spoken for themselves. These first protests are, perhaps, the latest step in a natural evolution: They have come out of groups of handicapped persons in community settings where new styles of organization have enabled individuals to speak more genuinely about themselves than ever before. (from an article on People First.)

live independently.
(b) advocating for resources which are needed and not presently available. Resources include such things as money, work, education, housing, legal and social justice.
(c) supporting the right to provide some services for themselves which are now being provided by parents and professionals. These services may include counseling, citizenship, education, community organizing, and social/ recreational activities.
(d) educating their community, both professional and disabled, as to their goals, capabilities and responsibilities.

People First of California was founded in 1976, and its governing board and officers are comprised of members of the organization, people with mental retardation themselves.

The Mohawks and Squaws is a non-subsidized group of persons who are retarded in the area of Boston, Massachusetts. Organized as a peer support group and social club, the Mohawks and Squaws has provided consultation to colleges and professional schools, parent and client groups on issues related to the rights and needs of persons who are retarded. It has also provided training in the public schools to acquaint school children with concerns of disabled persons. It provides support to members who reside in state schools and wish to join the community; it has a teen-age group and a Sunday drop-in Center.

The above-described organizations representing persons with retardation have a direct interest in this case because their constitutents will be directly affected by the outcome. All of these organizations promote the right of persons who are retarded to speak for themselves and to live as

independently as possible within their communities. Based on their own experiences, their members strongly believe that all persons with retardation can expand their abilities when provided services tailored to the individual in a family-sized community setting.[2]

AMERICAN COALITION OF CITIZENS WITH DISABILITIES

The American Coalition of Citizens with Disabilities (hereinafter referred to as ACCD) is an umbrella group, consisting or organizations of disabled people. Founded in 1973, ACCD's active membership consists of 89 organizations representing approximately seven million people. ACCD's member organizations include the National Association of the Deaf, the American Council of the Blind, the National Spinal Cord Injury Foundation, and others. ACCD's Board of Directors consists of persons with disabilities; its primary goal is to represent disabled people's interests and to join together the various voices and views of disabled people across the country to speak with one voice.

ACCD has been a major participant before the Congress in the formulation of policies and legislation concerning disabled people's needs and rights.[3]

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[2] Appendix A, attached to this brief, lists selected individuals represented by amici to further illustrate their membership.

[3] Review of Programs for the Handicapped, 1977: Hearings before the Senate Subcommittee on the Handicapped ofthe Comm. on Human Resources, 95th Cong., 1st Sess., 1325 (statement of Jan Jacobi, ACCD.) Education for All Handicapped Children Act, 1977: Hearings before the Senate Subcommittee on the Handicapped of the Comm. on Human Resources, 95th Cong., 1st Sess. 132 (statement of Frank Bowe, ACCD).

ACCD regularly conducts training sessions and prepares written materials on such subjects as: consumer involvement in the rehabilitation process, enforcement of the civil rights of disabled people, educational opportunities and rights of disabled children and adults, and independent living for severely disabled persons.

ACCD has an interest in this case because it represents organizations and coalitions of disabled people, including people who are retarded and multiply handicapped, from the national to the local level. Many of the people that ACCD represents have at one time been or still are living in institutions. ACCD conducts several activities designed to increase the alternatives available to allow people with severe disabilities to live in their communities. Presently it is representing individuals who are residents of Forest Haven, a residential institution for the District of Columbia located in Maryland, subject to a court order requiring placement. (Joy Evans v. Walter Washington, et al., C.A. #76-0293, (Dist. Ct. D.C.), June 14, 1978.)

INDEPENDENT LIVING CENTERS

The Center for Independent Living (hereinafter referred to as C.I.L.) is a non-profit corporation organized under the laws of the State of California. Founded in 1972, the major goal of C.I.L. is to provide support services and advocacy for persons with severe disabilities who would not be able to live independently in the community without such services and advocacy.[4] The C.I.L. Board of Directors consists of a majority of people with disabilities themselves; this philosophy and

[4]As the first independent living center in the country, C.I.L. has served as a national model for other such organizations across the country. In 1978, the Subcommittee on Select Education of the U.S. House of Representatives held 2 days of

commitment to control of the organization by disabled people is further evidenced by the high proportion of severely disabled persons who are administrators and staff at C.I.L.

In order to fulfill its goals, C.I.L. provides the following services to disabled people in its community: attendant care referral, housing referral, wheelchair repair, peer counseling, welfare advocacy, legal services, independent living skills training, and others.

Prime Movers, Inc., was founded in 1977 and operates out of Louisville, Kentucky. Its primary goal is to eliminate environmental factors such as barriers to housing, transportation and facilities, as well as attitudinal barriers which separate disabled people from their community.

Prime Movers has provided consultation services tocommunity organizations such as the Kentucky Cultural Complex Committee, the University of Louisville Urban Studies Center and the Kentucky Legislative Research Commission, among others, for devising methods to integrate all disabled people into community programs and facilities. Its major current project is the Disabled Housing Options Center, which will work to provide a range of integrated housing options for disabled persons.

The Center for Independence of the Disabled in New York, Inc., (hereinafter referred to as CIDNY) is a non-profit corporation organized under the laws of New York State in 1977. It is managed and directed by persons with disabilities.

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hearings at C.I.L. to receive testimony on the subject of implementing this model on a national level, which was accomplished in Title VII of the Rehabilitation Act Amendments of 1978, 29 U.S.C. §901 et seq., discussed infra at p.18. Oversight Hearings on the Rehabilitation Act of 1973: Hearings before the Subcommittee on Select Education and Labor, 95th Cong., 2nd Sess.

CIDNY's major goal is to provide services to allow severely disabled persons to live independently.

As a resource center for the disabled community, CIDNY provides: assistance with household management, independent living counseling, housing information, information on benefits and social service programs, peer counseling, vocational rehabilitation information, legal referral services, transportation information, and advocacy.

Access to Independence, Inc., is a non-profit corporation formed under the laws of the state of Wisconsin. Located in Madison, Wisconsin, its Board of Directors includes fifteen members, eight of whom are severely disabled.

Since 1978, Acess to Independence has been providing a range of supportive services to disabled persons: housing counseling and technical assistance; attendant recruitment, referral and counseling; information and referral services; a free university program to increase knowledge about independent living skills; a sheltered apartment program; peer counseling services; and within the Center, an on-the-job apprenticeship program.

The Washington Coalition of Citizens with Disabilities (hereinafter referred to as WCCD) was organized in 1977 as an umbrella of the following groups in Washington State: Arthritics in Action, Congress of the Physically Handicapped, Disabled in Action of Washington, Disabled Students Commission at the University of Washington, Puget Sound Chapter of the National Rehabilitation Association, Northwest Paralyzed Veterans of America, Polio Alums, Washington Association of the Deaf, and the King County Chapter of the Washington Council of the Blind.

WCCD provides services to Washington State disabled persons that include attendant referral,

peer counseling, and advocacy. WCCD has provided technical assistance on provision of services to include disabled persons to public agencies concerned with transportation, employment, housing, civil rights, chore services, in-home care entitlements, and health. WCCD's Board of Directors is composed entirely of disabled persons, and it is staffed primarily by disabled persons.

The Community Service Center for the Disabled, Inc., (hereinafter referred to as CSCD) is a consumer-controlled social and community service agency providing independent living services to more than 1,300 disabled persons a month in San Diego, California. Incorporated as a non-profit organization under the laws of the state of California in 1976, CSCD is San Diego's central clearinghouse for services and community education in issues relating to the positive movement of disabled people into the economic, social, personal and political mainstream. CSCD provides advocacy, personal helper referral, housing and transportation services to disabled San Diegans. It also provides peer counseling and job development services.

The Illinois Council of the Congress of the Physically Handicapped (hereinafter referred to as COPH) is a congress of 32 organizations of persons with physical disabilities and individual members, representing a constituency of five thousand members in the state of Illinois.

For the past fifteen years, COPH's activities and projects have provided information, referral, peer counseling and advocacy for persons with disabilities to help them gain full participation in society.

Access Living of Metropolitan Chicago is a consumer-operated service and advocacy organization that serves disabled persons in the Chicago area. It is affiliated with the Rehabilitation

Institute of Chicago. Based on the philosophy that disability does not have to mean dependency, Access Living's services include: housing referral, personal care assistant training and referral, educational programs for independent living, peer counseling, financial benefits counseling, independent living skills counseling, information referral and advocacy.

Paraquad, Inc., is a non-profit corporation organized in 1970 under the laws of Missouri to develop integrated living for the physically disabled in an accessible environment. Paraquad provides the St. Louis' disabled community with assistance in housing, barrier-free design, independent living counseling, peer counseling, consumer advocacy, and community relations.

Paraquad's Board of Directors is predominantly composed of persons with disabilities, reflected as well in Paraquad's staff composition.

The Stavros Foundation, Inc., was founded as a non-profit corporation under the laws of Massachusetts in 1974. It is a consumer-controlled independent living center with disabled persons forming a majority of its Board of Directors and staff.

Stavros provides peer advocacy counseling, individual and group advocacy, information and referral, and general consulting in independent living. It serves the Amherst, Massachusetts, area, in addition to the counties of Franklin, Hampshire, and Hamden.

Holistic Approaches to Independent Living, Inc., is a Denver-based non-profit corporation formed in 1978 under the laws of Colorado. It is organized and operated by persons with disabilities and provides attendant care referral and counseling in advocacy, housing, employment and recreation, as well as classes in independent living.

The Coalition for Barrier Free Living is a non-profit organization, formed in 1976 under the laws of the state of Texas. Its Board of Directors and staff are both composed predominantly of persons with disabilities. It provides the following services to persons with disabilities in Houston, Texas: service for deaf persons and blind persons, information and referral, financial benefits counseling, attendant referral, independent living skills training, training for developmentally disabled persons, and job development.

This case is of great interest to the Independent Living Center Amici because of the dual nature of their experiences as organizations composed of and representing persons with disabilities, on the one hand, and as providers of services to severely disabled people, on the other. Many of the people they serve would otherwise be forced to reside in nursing homes or institutions because there are so few alternatives available for community living.[5]

The experiences of Amici are that the social segregation and isolation associated with institutions are unnecessary and destructive to the individual, regardless of the severity or nature of the disability. A corollary experience of Amici is that the very nature of placement in an institution brings out those negative and dependent qualities in those who reside there; they are less able to speak for themselves, make decisions, or exert any other means of control over their lives.

Amici, as organizations representing and controlled by persons with disabilities, intend to rebut in this brief those assertions made by petitioners and Amici arguing for petitioners that disabled people, especially severely disabled people, are without the capability to speak for themselves

5. See, "National Significance Project: Programs and Resources", United Cerebral Palsy Association of California, February 1978, p. 15.

or make meaningful decisions about their lives. Such assertions are based on out-dated notions about people with severe disabilities.

Amici represent individuals with disabilities who would have been institutionalized decades ago. We now know that people with cerebral palsy, epilepsy, who are blind, deaf or mobility-impaired can function better in the community than ever expected; yet, when people with these disabilities were institutionalized for most of their lives, they displayed many characteristics that suggested they could not function or survive outside of the institution. As past victims of unnecessary institutionalization, Amici suggest that mental retardation is simply the last in a list of disabilities that used to be synonymous with "hopelessness."

As Amici will show, it has been recognized by Congress and is widely recognized by others that people with all disabilities function best when integrated into the community with appropriate services.

SUMMARY OF ARGUMENT

A central principle that emerges from a review of legislation concerning the rights of and services to persons with disabilities enacted during the previous decade is that persons with the most severe disabilities are capable of learning and growing, despite historical expectations to the contrary. Congressional committees have spent years researching this issue and receiving testimony from those directly involved and experts in the field. Congress brings to this issue "a specially informed legislative competence," Katzenbach v. Morgan, 384 U.S. 641, 655 (1966), which is due great consideration. The decision below is consistent with Congressional instructions that:

> all developmentally disabled individuals have potential for learning and growth. From this developmental model, it follows that custodial care--which is predicated on the assumption that certain individuals are essentially incapable of development--must be rejected... S. Rep. 94-160, 94th Cong., 1st Sess., at. 29 (1975).

The Congress has also recognized the need for disabled persons to speak for themselves and has acknowledged that they best represent their own interests. Amici believe that by advocating for themselves, they can rebut the commonly held assumption that they are not fully capable of doing so.

ARGUMENT

I. CONGRESS HAS REPEATEDLY RECOGNIZED THAT SEVERELY DISABLED PERSONS, INCLUDING THOSE WITH SEVERE AND PROFOUND RETARDATION, ARE CAPABLE OF GROWTH AND IMPROVEMENT.

Congress has dealt with the issues of protecting the rights of persons with disabilities and providing services to persons with disabilities many times. In doing so, it has made it amply clear that it rejects the view that the most severely disabled people, including persons with severe or profound retardation,[7] are not capable of progressing and improving their abilities to function, whatever their individual limitations. Even though Congress has definitively addressed this issue, it is repeatedly raised in the brief of Amici Congress of Advocates, et al., and is implicit in the dissenting opinion of the Third Circuit, written by Chief Judge Seitz, 612 F. 2d 84 at 125 (3d Cir. 1979).

In attempting to re-litigate by brief the factual issues that were disposed of by District Court Judge Broderick after 32 days of trial and disposed of previously by Congress as well, the Congress of Advocates paints a bleak and hopeless picture of the nature of severe and profound retardation, (Congress of Advocates brief, pp. 3-6). Citing materials suggesting that persons with profound retardation can barely function at all, referring to their status as "helplessness," and further stating that "the picture is not much

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[7] For the purpose of simplicity, Amici will use the term "severely disabled person" or "person with a severe disability" to refer to persons with severe or profound retardation and other severe disabilities.

brighter with respect to the 'severely' retarded...," the Congress of Advocates rely on frightening and out-dated stereotypes to make their argument.

The dissenting opinion of Chief Judge Seitz is based on the misconception that people with severe disabilities can only function at a very low level and that the type of care they receive does not affect their ability to function or improve. This leads the dissent to the conclusion that institutions need only meet certain minimal standards of cleanliness and staffing, without adressing the larger issues of the relationship between institutionalization and behavior.

This reasoning becomes apparent when the dissenting opinion is read for what it does not mention. Nowhere does it discuss the need for habilitation, training and the development of skills for less restrictive placement in the community. Several times the dissent lists the "necessities" that are provided at an institution: "food, shelter, medical care, and supervision," 612, F. 2d at 125. However, Congress and the District Court recognized that persons with severe disabilities are capable of more than receiving custodial care when they are provided appropriate training and habilitation, and the court correctly found that institutions cause residents to regress in those very skills and abilities needed to leave the institution. The Court also found that at Pennhurst there is no opportunity to practice newly learned skills; that the environment there was not conducive to habilitation; and that the restrictive, depressing routines of institutions such as Pennhurst actually contribute to the lack of ability to function that is commonly attributed to residents. 612 F 2d at 93.

Congress and the District Court could not ignore the effect of the institution on the behavior of individuals with severe disabilities

who have been housed in the institution for a large segment of their lives. Consistent with both the strong mandates of Congress on this issue, and with the experiences of Amici, the District Court found that retarded persons in large institutions suffer from "apathy, stunted growth and loss of IQ, and the smaller the living unit in which the retarded person lived, the higher the level of behavioral functioning shown by the individual." 612 F. 2d, at 93.

Amici represent individuals who do not need to read materials on the principles of normalization and integration to know their truth. They have lived in large-scale dehumanizing institutions, many of them with severe disabilities, and they have experienced firsthand the debilitating effects of such treatment. Because of the various enactments requiring community living arrangements rather than institutionalization, they have been able to move into their communities and function better than expected, in the majority of cases. They have not perished or been forced to return to the institution because they are incapable of avoiding "the hazards of freedom" which concerned Chief Judge Seitz. Because there are alternatives, they have been able to improve their abilities on a continual basis. Each person has no doubt that if they were forced to return to the institution, such improvement would diminish and stop.

The Congress has considered the experiences of Amici and others like them, as well as the available research and testimony of experts on the subject. The Senate Subcommittee on the Handicapped of the Human Resources Committee, which has jurisdiction over most of the legislation dealing with services to persons with disabilities and their rights, has spent several years hearing evidence and holding hearings on this subject. It has consistently produced legislation which recognizes the capabilities of severely disabled people, mandating that services be provided in

the community, structured to meet the needs of the individual.

A review of the record of the Subcommittee on the Handicapped and other committees that have acted in this area shows that Congress brings to this issue "a specially informed legislative competence," Katzenbach v. Morgan, 384 U.S. 641, 655 (1966), which this Court has held is the special prerogative of the legislative branch, having the power to assess and weigh various conflicting considerations of a complex issue. Based on this legislative competence, Congress has repeatedly acted to recognize the competence of severely disabled persons to live within their own communities and to grow and learn.

In the past decade, Congress has passed four major acts dealing with services to and the rights of people with disabilities: The Developmental Disabilities Assistance and Bill of Rights Act,[8] The Rehabilitation Act of 1973, as amended in 1974 and 1978,[9] the Education for All Handicapped Children Act,[10] and the White House Conference on Handicapped Individuals Act.[11] A review of these Acts and their legislative history reveals the following strong and interdependent themes: (1) Congressional recognition of the inherent strengths and capabilities of persons with severe disabilities (2) Recognition that such capabilities can best be fostered by the provision of services, education and training in the community, either in an independent living arrangement or in family-sized residential settings located in the general community for those in need of supervision and individualized assistance; (3) Requirements

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[8] 42 U.S.C. 600, et seq.

[9] 29 U.S.C. 701, et seq.

[10] 20 U.S.C. §§1232, 1401, 1405, 1406, 1411-20, 1453.

[11] 29 U.S.C. 701, Note (Dec. 7, 1974).

that such services be individually tailored to the disabled person's needs and abilities.

The legislative history of the Bill of Rights Act shows clearly that Congress recognized the capabilities of severely developmentally disabled persons to learn and grow. In discussing persons with multiple handicaps, the Senate Committee on Education and Labor declared, "A large percentage of all these citizens are so severely disabled as to require a lifetime array of services to reduce dependency or to develop potential abilities for personal and social functioning,"(emphasis added) S.Rep. 94-160, 94th Congress, 1st Sess., at 2(1975). Rather than relegating the most severely disabled to custodial care and institutions, Congress concluded that, from its own exhaustive research and several hearings, all disabled persons have the potential for growth.

Congress recognized that this growth must take place away from impersonal, institutionalized settings:

> Finally there is the view that developmentally disabled individuals are "diseased". They are viewed as sick and in need of constant care. This last model is gradually being replaced by a developmental view of mental retardation. Such a view stresses that all developmentally disabled individuals have potential for learning and growth. From this developmental model, it follows that custodial care - which is predicated on the assumption that certain individuals are essentially incapable of development - must be rejected...A final but critically important dimension of this new model is that developmentally disabled persons should live like non-developmentally (disabled) persons to the greatest degree possible. Every effort should be made to assist developmentally disabled persons to maximize their ability for self-care and to live normal lives. S.Rep.94-160 at 29.[12]

In the Rehabilitation Act of 1973, Congress required

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12. In the dissenting opinion, which would allow

that the state rehabilitation agencies, which receive their funding under that Act, reorder their priorities by serving first persons with "the most severe handicaps", 29 USC §701(a)(5)(A). The legislative history for this Act reveals a Congressional commitment to those whose disabilities were so severe that they had previously been denied rehabilitation services:

> However, the Committee, in changing the definition of handicapped individuals, also recognizes that there are handicapped individuals who may not have a vocational goal due to the severity of their handicap, their age, or other factors, but who can greatly benefit from rehabilitation services. While emphasizing that every effort should be expended to provide services to individuals so that they may reach a vocational goal, the Committee believes that individuals can benefit from services which will enable them to live more independently and to be more self-sufficient, and has directed the Secretary to study the feasibility of methods of accomplishing these goals. S.Rep.93-318 at 21,(1973) U.S. Code Congr. & Ad. News at 2095.[13]

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the continued institutionalization of the residents presently at Pennhurst, Judge Seitz states,"...what is the least restrictive environment for any particular individual is primarily a medical question", a view Congress has specifically rejected.

13. In 1978, Congress created Title VII of the Rehabilitation Act, which establishes comprehensive services for independent living, targeted to "any individual 'whose ability to function independently in his family or community is so limited by the severity of his disability that vocational or comprehensive rehabilitation services...are required to improve significantly...his ability to function independently in his family or community",29 USC § 796(a). In order to be eligible for grants under Title VII, a state must:

demonstrate that the State has studied and considered a wide variety of methods for providing comprehensive services to severely handicapped individuals(such as regional and community centers, halfway houses, and patient-release programs) and that the State will provide, to the maximum extent feasible, meaningful alternatives to institutionalization, 29 USC§796(d)(a)(2).

Thus, the comprehensive services for independent living are meant to supplement the community living arrangements that must currently be available.

During floor discussion on this new Title of the Rehabilitation Act, Senator Stafford, one of its authors, stated:

> The new "comprehensive services for severely handicapped individuals" (the original Senate Bill title) title establishes a new program directed to serve the most severely handicapped individuals. The disabled population to be served by this title...are those individuals who are currently not being served by the vocational rehabilitation programs. These unserved individuals are the severely handicapped and are usually found in our residential institutions. These severely handicapped individuals are going without necessary support services to aid in maximizing their potential. 124 Cong. Rec. S147, 15557 (daily ed. Sept. 20, 1978)

Senator Randolph, the chairman of the Subcommittee on the Handicapped, also remarked:

> At the outset, it must be clear that Section 119 of title I of S.2600 (i.e., Title VII) is targeted on those very severely handicapped persons who need multiple, continuing and probably lifelong services and treatment and who may have little or no vocational potential. It is well to note, however, that there are severely handicapped persons who have much to contribute - if they have access to necessary support services... Giving up too early on these individuals is inconsistent with the Committee's belief that every severely handicapped person is entitled to an opportunity to develop to the greatest extent

The Education for All Handicapped Children Act of 1975 established that every handicapped child, regardless of the type or severity of the handicap, has a right to receive an education. A specific requirement of this law is that each child receive an evaluation of his or her needs and abilities in the form of an individualized education plan, 20 USC §1412(2)(c). Another requirement is that each child should receive an education in the "least restrictive environment" for that child with appropriate accomodations and aids for that child, 20 USC §1412(5).

The legislative history of this act makes it clear that Congress recognized that all children, regardless of the severity of handicap, can benefit from education:

> The...bill has been designed to meet the following purposes...(2)to assure a priority in delivery of services to handicapped children who are not receiving educational services and those handicapped children with the most severe handicaps currently receiving inadequate education. (emphasis added) S.Rep. 94-168, 94th Cong., 1st Sess. at 13, 14, reprinted in (1975) U.S. Code Cong. & Ad. News, 1437, 1438.

> ...an attempt must be made to reach and provide services to children with the most severe handi-

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possible. 124 Cong. Rec. S147, 15548 (daily ed. Sept. 20, 1978)

Congressman Brademas, the chairman of the House Subcommittee on Select Education and a House author of the Bill, pointed out:

> Without question, this section epitomizes what the thrust of this bill is all about - moving away from the stereotype which views handicapped and disabled persons as being unable to exist in a community structure. Here, as in so many other areas, the direction is away from institutional settings and instead moving back into the mainstream. 124 Cong. Rec. H72, 3967 (daily ed. May 16, 1978).

> caps without regard to disability category. S. Conf. Rep. 94-455, 94th Cong., 1st Sess. at 38, reprinted in (1975) U.S. Co-e Cong. & Ad. News, 1491.

Senator Mondale, in articulating a basic concern which prompted the passage of the Act, stated:

> In the past, many children have simply been placed in institutions or segregated in schools and classes with little emphasis on adequate education and training. 121 Cong. Rec. S10983 (June 18, 1975).

When the House of Representatives considered the bill, Congressman Miller, a ranking member of the House Committee on Select Education, stated:

> There is no question that previous emphasis on institutionalization were not only dehumanizing, but neglected the basic precept that these persons have the same rights as other human beings. Most importantly, institutionalization more often than not effectively prevented any chances for a handicapped individual to perform productive work or to engage in any other meaningful occupation to the fullest possible extent of his capabilities. 121 Cong. Rec. H11350 (July 29, 1975).

Another stated purpose of the Act was to provide educational services to persons whose disabilities were so severe that they had previously not been expected to have the capability to successfully live in society. Congress explicitly repudiated these outdated stereotypes and further made it clear that this Act was intended to promote the capabilities of severely disabled people:

> The long range implications of these statistics are that public agencies and taxpayers will spend billions of dollars over the lifetimes of these individuals to maintain such persons as depen-

> dents and in minimally acceptable lifestyle. With proper education services, many would be able to become productive citizens, contributing to society instead of being forced to remain burdens. Others, through such services, would increase their independence, thus reducing their dependence on society. S.Rep. 94-169 at 9 (1975), U.S. Code Cong. & Ad. News, 1433.

In 1974, Congress enacted the White House Conference on Handicapped Individuals Act, 29 USC §701(1974), appropriating funds for a national conference held in Washington, D.C., in 1977. This conference was attended by people with all types of disabilities from all of the states and territories. One of the concerns that Congress wished to see addressed at this conference was the lack of alternatives and services for the severely disabled:

> The Committee has been distressed to find that services to the severely and multiply handicapped are virtually non-existent. It has discovered in hearings on the Rehabilitation Amendments of 1972 that individuals who are most in need of services have the most severe handicaps and are the last to receive them. S.Rep. 93-319 at 6 (1973).

Again, the legislative history for the White House Conference Act explicitly makes it clear that Congress was fully aware of the potential and capabilities of persons with the most severe disabilities and was also fully cognizant of the fact that those in institutions were least able to realize those capabilities. The reason was and is that resources to live in the community were not sufficiently available:

> All too frequently the adults with handicaps are forgotten because they no longer seem as appealing and therefore elicit the same sympathy as when they were children. The result has been institutional care or heavy dependency on family

> and friends because of a lack of services in the community to allow adults to function as independently as possible. S.Rep. 93-1297 at 51, (1974) U.S. Code Cong. & Ad. News 6401. [14]

II. CONGRESS HAS RECOGNIZED THAT PERSONS WITH DISABILITIES HAVE THE COMPETENCE TO SPEAK FOR THEMSELVES.

Amici have felt it is important to present their views to this Court because they directly represent the people who will be most affected by the outcome of this litigation. While other groups historically have spoken for disabled people - the professionals, the administrators, the parents, the staff - there no longer is a need for them to do so exclusively. With the advent over the past decade of the organizations that have joined this brief, and others, there are now strong, organized voices of disabled people themselves. With the birth of new groups such as People First, representing people who are retarded, there is now a voice of persons who have heretofore been sent off to institutions and, in many instances, forgotten.

Amici's views and experiences on this matter should not be taken lightly. As previously noted,

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14. It is likely that Congress was also aware that historically, the dual policy of establishing institutions and providing community services has not succeeded:

> There is an expansive character to institutions that is not easily curbed - and this in two senses. For one, institutions appear so convenient and functional to the ordinary citizen, so easy a way of getting rid of troublesome or ugly or needy persons, that as long as the institutional option exists, alternatives will never be properly organized and supported. For another, the heads and direct beneficiaries of institutions, be they employees or building contractors, have a way of dominating the budget so as to

Amici have participated in numerous hearings and other forums addressing these issues. In many instances, their experiences and successes have been the driving force behind new programs and concepts allowing people with the most severe disabilities to move back into their own communities with the dignity and back-up services necessary for success.

Amici are the only parties who can represent to this Court that they know from first-hand experiences of the capabilities and strengths of people with disabilities. They do not distinguish heavily between "moderate" and "profound" disabilities because they know from their own lives that the major factor influencing their ability to grow and achieve independence is the environment. They represent countless individuals who were once viewed as "hopeless cases" and who are now managing their own lives, some with more supervision than others.

The Congress has recognized the need for disabled people to speak for themselves and represent their own interests, and it has also further recognized the barriers that disabled people have had to face to do so:

> More than any other minority group, individuals with disabilities have been affected by policy decisions made at every level of government which are developed all too frequently without their continued participation. Until this nation has the foresight to include in all of its planning the need to make all areas of society accessible and usable to individuals with handicaps, they will continue to be excluded and will have little or no opportunity to achieve their basic human right of full participation in life and society. S.Rep. 93-1297 at 56 (1974).

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prevent the growth of quality alternatives. David Rothman, "Can De-Institutionalization Succeed?", New York University Education Quarterly, Fall 1979, p. 16.

In addition, those who purport to speak for disabled people often are limited in their ability to do so to the extent that disabled people themselves can. Often, there are differences of viewpoint, experience, expectation and need that divide the loyalties of professionals, parents or others who have responsibilities in addition to their concerns for the conditions or rights of persons with disabilities.

The Congress recognized this, to the extent that parents are not always fully informed about the capabilities of their disabled children:

> Parents of handicapped children all too frequently are not able to advocate the rights of their children because they have been erroneously led to believe that their children will not be able to lead meaningful lives - however, over the past few years, parents of handicapped children have begun to recognize that their children are being denied services which are guaranteed under the Constitution. S.Rep. 94-168 at 9 (1975) U.S. Code Cong. and Ad. News at 1433.

Indeed, Amici are fully aware that sometimes parents tend to be overprotective of their disabled children, as they can be with children in general, and that they tend to underestimate their capabilities as well. This is fully understandable, since very often a parent will turn first to medical professionals to seek information when he or she learns his child is disabled; those very professionals can be instrumental in implanting negative expectations.

Nevertheless, Congress understood that sometimes parents can be misled into defending positions that are actually defeating to the growth and independence of their children.

When the White House Conference on Handicapped Individuals Act, 29 USC §701, was enacted, Congress made it abundantly clear that it was primarily interested in receiving recommendations from disabled per-

sons regarding solutions to thei problems. It created a National Planning and Advisory Council, specifying that at least ten members should be disabled, §302(b)(1) of the Act. The Council was given authority to "engage such individuals with handicaps and additional personnel as may be necessary", §303(a)(5) of the Act. The Conference was attended by hundreds of disabled persons who addressed a multiplicity of issues, following the Congressional mandate:

> It is essential that recommendations be made to assure that all individuals with handicaps are able to live their lives independently and with dignity, and that the complete integration of all individuals with handicaps into normal community living, working, and service patterns be held as the final objective... §301(6) of the Act.

Amici believe that by advocating for themselves they can best rebut the commonly held assumption that they are not fully capable of doing so. Congress has consistently confirmed the fact that disabled people themselves hold invaluable expertise regarding the solutions to the obstacles that impede their capabilities. It has relied on their expertise in formulating the legislation designed to remove those obstacles, and it has given disabled people the responsibility to manage their own community programs, 29 USC 796(e).

CONCLUSION

There is no doubt that Congress has thoroughly considered the issue of the most appropriate method of providing care and habilitation to persons who are severely disabled and that it has weighed the evidence for and against the continuation of the policy of institutionalization - and rejected it. The legislative history of all of the major Acts concerning services to disabled persons and the protection of their rights provides the Congressional rationale for that rejection: the recognition that even those persons with the most severe

disabilities are entitled to more than mere custodial care, and that all can benefit from services that are individually tailored and community-based. This Court can do no less. We urge this Court to consider these basic principles when rendering its decision and to affirm the opinion below.

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APPENDIX A

CASE HISTORIES OF SELECTED INDIVIDUALS REPRESENTED BY AMICI

PEOPLE FIRST INTERNATIONAL:

Bob Borneman: Mr. Borneman is 30 years old; he has been classified severely retarded, both intellectually and adaptively by standards set by the American Association on Mental Deficiency (hereinafter referred to as AAMD). He has resided for twenty years at the Fairview State Hospital in Oregon where he displayed severe behavior problems for which he was treated with drugs. During the first three years of his life, he required extensive medical treatment in hospitals and was abandoned by his family. He was placed in Fairview at the age of four.

In 1975, at the age of 24, he was placed in the community in a group home with other people with retardation. Since then, he has steadily improved to the point that his resident progress record reflects that he has learned nearly all the skills necessary for community living. He holds a semi-competitive job at the Veterans Administration in the microfilm department, and requires no behavior modifying drugs. He is regarded in his group home as a leader and a model and has developed a very pleasant personality. Within a year, he is expected to be able to live in a satellite apartment.

Jim Gleason: Mr. Gleason was born in 1944 and subsequently diagnosed as severely retarded by AAMD standards; he also has a physical disability. He was admitted to Fairview State Hospital in 1947 and resided there for 25 years. While living in the institution, he was not physically active and not expected to ever be able to do much.

He was discharged from the state hospital in 1972 and now resides in a group home. He works at Goodwill Industries and has twice been named worker of the month. He is presently on the waiting list to live in a satellite apartment. Last summer he traveled independently by airplane to a dude ranch in Colorado where he spent his vacation. Since he has left the institution, he has developed many abilities never previously expected; he regularly reads the newspaper and is the source of information about current events and activities for other residents in his group home.

Barbara Kluting: Ms. Kluting was born in 1944 and diagnosed as severely retarded by AAMD standards, with Downs Syndrome. In 1969 she was admitted to Fairview State Hospital and resided there for fourteen years. While there, she displayed the characteristics of a very shy personality and very rarely spoke.

In 1974, she left the institution for a group home. She now works at Garten, a local activities center for persons with retardation specializing in recycling. She has twice been named worker of the month and can now perform all the skills listed on the resident progress record such as self help skills, home skills, personal hygiene, etc. While she was never expected to be able to display such skills and attributes in the institution, she now is no longer shy and talks much more. She has a boyfriend in the community and someday wishes to marry.

Geraldine Miller: Ms. Miller was born in 1941 and later diagnosed as severely retarded by AAMD standards; she also has hypothyroidism, hypoglycemia and a severe speech impediment. She was admitted to Fairview State Hospital in 1953 at the age of 12 and resided there for 23 years. While in the institution, she was very shy and did not get a chance to speak for herself very much due in part to her speech impediment.

In 1976, she was placed in the community in a group home. She works at Goodwill Industries where she has twice received notice as the worker of the month. Since leaving the institution, she has developed a more assertive personality and requests others to take the time to listen to what she has to say even though her speech impediment makes listening somewhat tedious. She has a boyfriend in the group home where she now resides; they plan to marry soon and continue to live there in a double room.

All of the above-described persons are members of People First International.

CENTER FOR INDEPENDENT LIVING

Nancy Rosenbloom: Ms. Rosenbloom is 32 years old. She has severe cerebral palsy and her IQ tests at 60, putting her into the category of mentally retarded. Her speech is mostly unintelligible, except to those with whom she speaks regularly. She requires total personal care to help her bathe, dress and eat. She is increasing her mobility through use of an electric wheelchair operated by mouthstick.

She moved to Berkeley, California, a year ago from a residential program in New York City. A year before moving to Berkeley, she was able to visit there and was attracted by the large number of visibly disabled people in that community who lived in their own apartments and were quite mobile. She immediately decided to move there and did so after a year of planning.

She now resides in her own apartment with a live-in attendant whom she has hired herself, who is paid through funds for Home Support Services from the County of Alameda. As well as assisting her with personal care activities, her attendant also helps her with money management. She is a client of the Center for Independent Living, from which she receives services that assist her to live independently.

Nos. 79-1404, 79-1408, 79-1415, 79-1489

In the Supreme Court of the United States

OCTOBER TERM, 1980

PENNHURST STATE SCHOOL AND HOSPITAL, ET AL.,
PETITIONERS,
v.
TERRI LEE HALDERMAN, ET AL.,
RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

AMICI CURIAE BRIEF OF THE PLAINTIFFS IN *BREWSTER v. DUKAKIS*, (D. Mass.); *CONNECTICUT ASS'N FOR RETARDED CITIZENS v. THORNE* (D. Conn.); *KENTUCKY ASS'N FOR RETARDED CITIZENS v. CONN* (W.D. Ky.); *WUORI v. ZITNAY* (D. Me.); *MASSACHUSETTS ASS'N FOR RETARDED CITIZENS v. DUKAKIS* (D. Mass.); *MICHIGAN ASS'N FOR RETARDED CITIZENS v. SMITH* (E.D. Mich.); *GARRITY v. GALLEN* (D. N.H.); *NEW YORK STATE ASS'N FOR RETARDED CHILDREN v. CAREY* (E.D. N.Y.); *ISOMONE v. GARRAHY* (D. R.I.); *WASHINGTON ASS'N FOR RETARDED CITIZENS v. THOMAS* (W.D. Wash.); *MEDLEY v. GINSBERG* (S.D. W.Va.); THE MASSACHUSETTS ASSOCIATION FOR RETARDED CITIZENS; KENTUCKY ASSOCIATION FOR RETARDED CITIZENS; WASHINGTON ASSOCIATION OF RETARDED CITIZENS; MASSACHUSETTS ASSOCIATION FOR MENTAL HEALTH; NEW YORK CIVIL LIBERTIES UNION; MASSACHUSETTS DEVELOPMENTAL DISABILITIES LAW CENTER; VERMONT DEVELOPMENTAL DISABILITIES LAW PROJECT; GREATER BOSTON LEGAL SERVICES, INC.; JUVENILE LAW REFORM PROJECT; AND, WESTERN CENTER ON LAW AND PROVERTY, INC. IN SUPPORT OF THE RESPONDENTS.

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Table of Authorities Cited.

CASES.

Baker v. Carr, 369 U.S. 186 (1962) 31

Baxtrom v. Herold, 383 U.S. 107 (1966) 13

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Boyd v. Registrars of Belchertown, 368 Mass. 631, 334 N.E.2d 629 (1975) 31

Brewster v. Dukakis, C.A. 76-4423-F (D. Mass., 1978) passim

Connecticut Association for Retarded Citizens v. Thorne, C.A. 1478-653 (D. Conn., filed Dec. 6, 1978) 2n

Cruz v. Hauck, 515 F.2d 322 (5th Cir. 1975), cert. denied, 424 U.S. 917 (1976) 40

Davis v. Watkins, 384 F.Supp. 1196 (N.D. Ohio, 1974) 11, 29, 38n

Dixon v. Harris, C.A. 74-285 (D.D.C. April 30, 1980) 32, 38n, 40n

Dixon v. Weinberger, 405 F.Supp. 974 (D.D.C. 1975) 29, 39n

Doe v. Hudspeth, C.A. J. 75-36(N) (S.D. Miss. 1977) 32

Elrod v. Burns, 427 U.S. 347 (1976) 31

Evans v. Washington, 459 F.Supp. 483 (D.D.C. 1978) 11, 29, 32, 41n

Ex parte Peterson, 253 U.S. 300 (1920) 39

Garrity v. Gallen, No. 78-116 (D.N.H., 1978) 2n, 7n, 12n, 42n

Gary W. v. State of Louisiana, 437 F.Supp. 1209 (E.D. La. 1976) 29, 38n, 40, 42n

Halderman v. Pennhurst, 446 F.Supp. 1295 (E.D. Pa. 1977) passim

Halderman v. Pennhurst State Sch. & Hospital, 612 F.2d 84 (3d Cir. 1979) passim

Hart v. Community School Board, 383 F.Supp. 699 (S.D. N.Y. 1974), aff'd, 512 F.2d 37 (2d Cir. 1975) 40

Hills v. Gautreaux, 425 U.S. 284 (1976) 30, 31

Horacek v. Exon, 357 F.Supp. 71 (D. Neb., 1975) 32, 38n

Hutto v. Finney, 437 U.S. 678 (1978) 30, 41, 42

Isomone v. Garrahy, C.A. 77-727 (D.R.I., 1977) 2n

Kentucky Association of Retarded Citizens v. Conn., C.A. No. 78-0157L (A) (W.D. Ky., March 21, 1980) passim

Massachusetts Association for Retarded Citizens v. Dukakis, C.A. 75-5023-T and 75-5210-T (D. Mass., 1979) passim

Medley v. Ginsberg, C.A. 78-2099 CH (S.D. W. Va., 1978) 2n

Michigan Association for Retarded Citizens v. Smith, C.A. 8-70384 (E.D. Mich., 1979) 2n, 32, 38n

Milliken v. Bradley, 433 U.S. 267 (1977) 20, 31, 42

Mills v. Board of Education, 348 F.Supp. 866 (D.D.C. 1972) 20, 40

Monroe v. Pape, 365 U.S. 167 (1960) 30

Moore v. LeFlore County Board of Election Commissioners, 361 F.Supp. 603 (N.D. Miss, 1972), aff'd, 502 F.2d 621 (5th Cir. 1974) 40

Morgan v. Kerrigan, 523 F.2d 917 (1st Cir. 1975), 530 F.2d 401 (1st Cir. 1976), cert. denied, 426 U.S. 935 (1976) 39

National Council of Community Mental Health Centers, Inc. v. Weinberger, 361 F.Supp. 897 (D.D.C. 1973) 22

National League of Cities v. Usery, 426 U.S. 833 (1976) 30

New York State Association for Retarded Children v. Carey, C.A. 72-C-356/357 (E.D. N.Y., 1975) passim

New York State Ass'n for Retard. Child., Inc. v. Rockefeller, 357 F.Supp. 752 (E.D. N.Y. 1973) passim

Parham v. J.R., 442 U.S. 584 (1979) 13, 14

Pennsylvania Association for Retarded Citizens v. Pennsylvania, 343 F.Supp. 279 (E.D. Pa. 1972) 20

Procunier v. Martinez, 416 U.S. 396 (1974) 31

Quern v. Jordan, 440 U.S. 332 (1979) 31

Rizzo v. Goode, 423 U.S. 362 (1976) 30

Rogers v. Okin, 478 F.Supp. 1342 (D.Mass. 1979) 13

Saville v. Treadway, 404 F.Supp. 430 (M.D. Tenn. 1974) 29

Sidles v. Delaney, C.A. C 75-200A (N.D. Ohio 1976) 32

Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. 1 (1971) 29, 42

United States v. Nixon, 418 U.S. 683 (1974) 30

Washington Association for Retarded Citizens v. Thomas, C.A. 79-1235 V (W.D. Wash., filed June 16, 1978) 2n

Welsch v. Dirkswager, C.A. No. 4-72 c. 451 (D. Minn., 1977) 34n, 41

Welsch v. Likins, 373 F.Supp. 487 (D. Minn., 1974), aff'd in part and remanded in part, 550 F.2d 1122 (8th Cir. 1977) 11, 13, 29

Wuori v. Zitnay, C.A. 75-80-SD (D. Me., 1978) passim

Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) 11, 14

Wyatt v. Hardin, C.A. 3195-N (M.D. Ala., Jan. 15, 1980) 38n, 39n, 40n

Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972) 11, 12, 29, 32

Younger v. Harris, 401 U.S. 37 (1971) 30

STATUTES.

20 U.S.C. § 1401 (Education Act) 16, 20, 21
§ 1412 (5)(B) 20
29 U.S.C. § 701 (Section 504) 16, 19
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42 U.S.C. § 1397 (Title XX) 16, 18
§ 1397(4) 18
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§ 2689(b)(1) 21
§ 6000 et seq. (DD Act) 16
§ 6000(a)(5) 17
§ 6010(2) 18
§ 6063(b)(3)(B) 17
Fed. R. Civ. P. 53 39
U.S. Sup. Ct. R. 36.2 1n
Calif. Welf & Insti. Code § 5450 (West) 24
Colo. Rev. Stat. § 2710.5-101 24
Fla. Stat. Ann. § 393.062 (West Supp. 1978) 10n
Ky. Rev. Stat. § 202B 28n
§ 210 24
§ 210.410(6) 24
Mass. Gen. Laws c. 19, § 17-24 24, 27n
1966 Mass. Acts c. 735 27n
Me. Rev. Stat. c. 221, § 2601 & c. 186-A, § 2141 24

Me. Rev. Stat. c. 223, § 2611 & 2643 24
1901 N.H. Laws, c. 102, § 1 7n
N.H. Rev. Stat. Ann. §§ 171A:1 et seq. and 126-A:39 24
N.Y. Mental Hyg. Law § 1302 (McKinney) 23
45 C.F.R. § 121a. 550 20
104 C.M.R. 20.00 34n
42 Fed. Reg. 22,676 (1977) 19
43 Fed. Reg. 4016 (1978) 18

MISCELLANEOUS.

Alternative Care Package, Report of the Massachusetts Department of Public Health (1974) 43n
American Association on Mental Deficiency, Manual on Terminology and Classification in Mental Retardation 5 (H. Grossman rev. ed. 1977) 7n
American Psychiatric Association, Task Force on the Right to Treatment, Position Statement on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded, reprinted in 134 Am. J. Psych. 354 (1977) 10n
L. Bachrach, Deinstitutionalization: An Analytical Review and Sociological Perspective (ADM 76-351) (1976) 27n
Bassuk and Gerson, Deinstitutionalization and Mental Health Services, 238 Scientific American 46 (February 1978) 28n
Braddock, "Opening Closed Doors: The Deinstitutionalization of Disabled Individuals," 99 (Council for Exceptional Children, 1977) 36n
Chayes, The Role of Judges in Public Law Litigation, 89 Harv. L. Rev. 1281 (1976) 39

C. Cherrington and G. Dybwad (eds.), New Neighbors: Retarded Citizens in Quest of a Home (1974) 33n

Coleman and Gilbert, Stalking the Least Restrictive Alternative 31 (1979) 27n

Comptroller General of the Unites States, Report of the Congress, Returning the Mentally Disabled to the Community: Government Needs to Do More i-x (HRD 76-156) (1977) 5, 16, 22, 24n, 26, et seq.

Compulsory Sterilization of the Mentally Ill and Retarded: In re Sterilization of Moore, 30 SW. L.J. 775 (1976) 9n

118 Cong. Rec. S525 (Jan. 20, 1972) 20

118 Cong. Rec. S9495 (March 22, 1972) 19

121 Cong. Rec. 16,516-17 (June 2, 1975) (Comments of Sen. Williams) 17

S. Davis, Social Control of the Mentally Deficient 130 (1930) 9n

Deinstitutionalization, Public Employee (May 1979) 28n

Developments in the Law: Civil Commitment of the Mentally Ill, 87 Harv. L. Rev. 1190 (1974) 13n

Dorsen, Separation of Powers and Federalism: Two Doctrines with a Common Goal, 41 Albany L. Rev. 53 (1977) 31

Ferleger, Loosing the Chains: In-Hospital Civil Liberties of Mental Patients, 13 Santa Clara Lawyer 447 (1973) 13n

Flynn and Nitsch (eds.), Normalization, Social Integration and Community Services (1980) 36, 43n

J. Geller, "Time for More Debate About Hospital," Hampshire Gazette, June 26, 1980 at 6, col. 3 7n

E. Goffman, Asylums xiii (1961) 7n, 14

S. Herr, Legal Protection for Residents of Institutions for the Mentally Handicapped in New York 57-58 (1979) (unpublished D. Phil. thesis in Harvard Law School Library) 9n

S. Herr, The New Clients: Legal Services for Mentally Retarded Persons 41 (1979) 9n, 15

Herr, The New Clients, 31 Stan. L. Rev. 563 (1979) 37

J. Hollis, P. McNelly, W. Jones, Special Team Report: Visits to the Y Buildings and Madarona Building at Fircrest School 3-4 (1980) 11n

H.R. Rep. No. 1188, 95th Cong., 2d Sess. reprinted in [1978] U.S. Code Cong. and Ad. News 7533 17

Implementation Problems in Institutional Reform Litigation, 91 Harv. L. Rev. 428 (1977) 37, 38n

Interim Report on the Colin Anderson Center 6-7 (1980) 13n

Kentucky Legislative Research Commission, Society's Stepchildren: The Mentally Retarded, 1974 26

Koenig, P., "The Problem That Can't Be Tranquilized," New York Times (magazine) (May 21, 1978) 28n

Letter of Jerald L. Stevens, Secretary of the Executive Office of Human Services, April 5, 1976 28n

Massachusetts Dept. of Mental Health, Five Year Plan (1977) 26

Menolascino, Challenges in Mental Retardation 46 (1977) 9n

"Mental Retardation: The Known and the Unknown," President's Commission on Mental Retardation (DHEW No. (OHD) 76-21008) 33n

Miss Nelson Dies: Confined for a Century, New York Times, Feb. 1, 1974, at 30, col. 2 10n

5A Moore's Federal Practice, ¶ 53.05 (3rd ed. 1975) 39

New Hampshire Division of Mental Health, Mental Retardation Plan (1979) 26

Plotkin and Gill, Invisible Manacles: Drugging Mentally Retarded People, 31 Stan. L. Rev. 637 (1979) 13n

President's Committee on Mental Retardation, Past and Present 3 (1976) 8n, 9n

President's Panel on Mental Retardation, Report to the President 143 (1962) 24n

Report to the Court 39 (June 1979) 12n

Report of Kentucky Division of Licensing and Regulation, 1977 13n

Report of Special Master 2 (March 19, 1979) 11n

S. Rep. No. 160, 94th Cong., 1st Sess. at 32 18

S. Rep. No. 94-168, Cong., 1st Sess. reprinted in [1975] U.S. Code Cong. and Ad. News 1433 21

Service Integration of Deinstitutionalization Project (SID) Report, Vol. 5 (Cost/Benefit Analysis (DHEW)) (1975) 36

D. Rothman, The Discovery of the Asylum 130-131 (1971) 8n

P. Tyor, Segregation or Surgery: The Mentally Retarded in America 160 (1972) 8n

[1975] U.S. Code Cong. and Ad. News 469, 540 21

[1978] U.S. Code Cong. and Ad. News 9042, 9048 21

Wolfensberger, The Origin and Nature of Our Institutional Models, reprinted from Presidents Committee on Mental Retardation, Changing Patterns in Residential Services for the Mentally Retarded 31-34 (1969) 8n, 9n

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS
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AMICI CURIAE BRIEF OF THE PLAINTIFFS IN *Brewster v. Dukakis*, et al.

INTEREST OF AMICI CURIAE

Amici Curiae* are eleven plaintiff classes of retarded and disabled residents[1] of institutions who are enforcing their right

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* The consent of all parties to the filing of this brief is on file with the Court, pursuant to U.S. Sup. Ct. R. 36.2.

[1] Since most Amici are or represent retarded persons, that term will be used throughout this brief. Amici also include individuals suffering from other disabilities, such as the mentally ill, the elderly, and emotionally troubled children who similarly are unnecessarily and inappropriately institutionalized.

to placement in less restrictive, community living arrangements;[2] four organizations of consumer advocates and parents and friends of individuals with disabilities, all of whom have participated as plaintiffs or plaintiff-intervenors in litigation involving the rights of retarded persons to placement in appropriate community alternatives;[3] and six public interest organizations which provide legal services and representation to disabled persons who reside in institutions but who desire to live in less restrictive settings in their communities.[4]

Amici have a unique interest in this litigation. Amici include tens of thousands of retarded persons who are presently

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[2] The plaintiffs in *New York State Association for Retarded Children* v. *Carey*, C.A. 72-C-356/357 (E.D.N.Y., Consent Decree April 30, 1975) (hereafter *NYSARC* v. *Carey*); *Wuori* v. *Zitnay*, C.A. 75-80-SD (D.Me., Consent Decree July 21, 1978); *Brewster* v. *Dukakis*, C.A. 76-4423-F (D. Mass., Consent Decree Dec. 7, 1978); *Massachusetts Association for Retarded Citizens* v. *Dukakis*, C.A. 75-5023-T and 75-5210-T (D.Mass., Consent Decree Feb. 16, 1979) (hereafter *MARC* v. *Dukakis*); *Michigan Association for Retarded Citizens* v. *Smith*, C.A. 8-70384 (E.D.Mich., Consent Decree Sept. 15, 1979) (hereafter *Michigan ARC* v. *Smith*); *Isomone* v. *Garrahy*, C.A. 77-727 (D.R.I., filed Dec. 9, 1977); *Garrity* v. *Gallen*, No. 78-116 (D.N.H., filed April 1978); *Medley* v. *Ginsberg*, C.A. 78-2099 CH (S.D.W.Va., filed April 21, 1978); *Washington Association for Retarded Citizens* v. *Thomas*, C.A. 79-1235V (W.D. Wash., filed June 16, 1978); *Connecticut Association for Retarded Citizens* v. *Thorne*, C.A. 1478-653 (D. Conn., filed Dec. 6, 1978) (hereafter *CARC* v. *Thorne*); *Kentucky Association of Retarded Citizens* v. *Conn*, C.A. No. 78-0157L(A) (W.D.Ky., March 21, 1980) (hereafter *KARC* v. *Conn*) are all residents of mental institutions in their respective states.

[3] The Kentucky, Massachusetts and Washington Associations for Retarded Citizens and the Massachusetts Association for Mental Health are non-profit organizations representing the interests of disabled persons in their respective states. They are all dedicated to insuring that handicapped persons are provided appropriate and adequate services in order that each may live as full and normal a life as possible.

[4] The Western Center on Law and Poverty in California, the Developmental Disabilities Center in Massachusetts, the New York Civil Liberties Union, Vermont Developmental Disabilities Law Project, and Greater Boston Legal Services, including its Juvenile Law Reform Project, are all non-profit organizations which are actively involved in representing institutionalized handicapped clients of various ages.

and needlessly confined and segregated in state institutions solely as a result of the absence of structured and supportive living environments in the community. Thus, unlike the states or professional organizations which have filed briefs in this litigation, Amici's very liberty and future may well rest on the Court's resolution of this case.

Both the majority and dissenting opinions of the Court of Appeals frankly acknowledged the illegal and inhumane conditions under which the residents of the Pennhurst State School are forced to live.[5] *Halderman* v. *Pennhurst State School & Hospital*, 612 F.2d 84, 93, 117 (3d Cir. 1979). Amici presently suffer the same indignities, experience the same pain and regression, are denied the same fundamental rights, and are similarly dependent upon the state for the provision of decent and adequate habilitation in the least restrictive setting as the residents of Pennhurst. Unless the decision of the court below is upheld, they will continue to exist under those same conditions indefinitely.

Moreover, Amici also include tens of thousands of retarded persons who presently are confined in state institutions but who have secured their right to habilitation in community programs through either court decisions or consent decrees. They share the hope that these federal orders, which depend in part on the cooperation of state officials for their effective and timely implementation, will not be undermined by a subsequent decision of this Court. Most of these cases are in delicate stages of remedial enforcement. All reflect a sensitivity to the particular policies, conditions, and realities of each state's chosen mechanism to create a comprehensive system of community services. While a consensus exists in these and other states that community programs are preferable to segregated institutions for retarded citizens,[6] the precise source of this right has yet to be articulated by this Court. A

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[5] Even the Amici states of Illinois and New Hampshire concede that the conditions at Pennhurst are deplorable. Brief of Amici Curiae Illinois *et al.* at 2.

[6] Brief of Amici Curiae Illinois *et al.* at 1.

decision denying or narrowing this critical right may not only halt the trend toward developing institutional alternatives, but might even reverse the progress made to date.

Amici, as plaintiff class members and concerned organizations, will discuss the real effects of institutional confinement on their daily lives, as well as on the lives of their family members, friends, and the forgotten people who they represent. Amici will also describe in detail the existing commitments of numerous states to relieve them of this segregated existence and provide them with normalized community living arrangements. By tracing the immediate beneficial effects of these consent orders, Amici will demonstrate the visible results of adequate and integrated community services created pursuant to federal and state policies.

SUMMARY OF ARGUMENT

The history of institutions for the retarded is a tragic chronicle of increasing segregation, degradation, and human suffering. The conditions under which institutionalized persons are confined and the resulting harm occasioned by the everyday reality of those facilities have led virtually every lower court which has confronted the issue to declare that retarded persons are full citizens entitled to at least minimally adequate habilitation in an environment least restrictive of their fundamental liberties. The Court of Appeals, in finding that Pennhurst denied its residents this basic right, did little more than adopt an emerging judicial principle and apply it to an admittedly deplorable institution.

In recognition of the well-documented failure of institutions to provide even a decent living environment, first the Congress and then later a majority of the states enacted into law the accepted policy that structured and home-like community living arrangements were the only feasible alternatives to massive,

custodial facilities for the retarded.[7] These legislative judgments have been incorporated into a compendium of federal and state statutory schemes which create a preference for community care, as found by the Court of Appeals. Unfortunately, these legislative intentions have not been translated into meaningful realities for the institutionalized retarded. Comptroller General of the United States, Report to the Congress, *Returning the Mentally Disabled to the Community: Government Needs to Do More* i-x (HRD 76-156) (1977) (hereafter cited as *Report to the Congress*). For a variety of bureaucratic reasons and particularly as a result of the parochial interests of the institutions themselves, *Id.*, Pennsylvania, like most states, has not responded to the will of elected officials and to the consensus of professionals, thereby leaving yet another generation of retarded citizens to suffer the indignities of a life of institutional confinement.

To enforce these unfilled statutory and policy mandates, disabled citizens, like other discrete minorities before them, have had no recourse but to turn to the courts for relief. Not only were the courts shocked at what they did see — the horrors of institutional care — but they were dismayed at what they did not see — adequate and available community alternatives. Although not in Pennsylvania, these legal actions often prompted recalcitrant state officials to finally move forward with the long inactive plans for the creation of comprehensive community care systems, which usually then resulted in cooperative efforts by all concerned parties to remedy this history of abuse. Whether by consent decree or court order, however, the judicial enforcement of existing law has been the essential factor in finally prompting the development of less restrictive alternatives to institutions. The

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[7] Not surprisingly, a small minority of people and a few professionals take issue with this accepted policy and with the legislative judgments which incorporate it. But where all the diverse parties to this litigation concur as to the parameters and import of this policy, the untimely protest of a disgruntled few cannot be allowed to alter the legislative judgments which incorporate these policies. *See* Pet. App. 135a.

visible effects of structured, supportive community residences have already made a dramatic difference for thousands of retarded citizens who otherwise would have been relegated to a life of institutional monotony and who instead are living normal and productive lives in the community. Given this historical reality, the relief ordered by the Court of Appeals was appropriate and not unnecessarily intrusive on the ability of the state to care for its retarded citizens in a safe and decent environment.

ARGUMENT

I. Institutions for the Mentally Disabled are Traditionally Large, Old, Remote and Inaccessible Places Which Segregate Retarded Citizens From the Rest of Society.

The federal and state statutes and policies which mandate the creation of supervised community living arrangements[8] were formulated in direct response to the documented failure of institutions to provide even minimally decent care for their retarded residents. It is precisely this history, the current reality of institutional existence, and the failure of local officials to implement those mandates that has prompted retarded citizens in several states to seek judicial enforcement of their right to live in the least restrictive environment.

A. Institutions Developed in Response to Obsolete and Ultimately Discredited Views of Retarded Persons as Socially Unfit and Inferior Individuals.

When the District Court, after hearing thirty-two days of testimony, observed that "[a]t its best, Pennhurst is typical of large residential state institutions for the retarded," *Halderman* v. *Pennhurst*, 446 F. Supp. 1295, 1302-03 (E.D. Pa.

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[8] *See* Part II *infra*.

1977), it was echoing the view of scholars, lawyers and mental retardation professionals that public institutions for the retarded share a common history and have a common effect on the people they confine.

The institutions in which the retarded citizens represented by Amici reside are strikingly similar. Generally, they are old, remote and inaccessible places created to separate the retarded from the rest of us.[9] They were developed largely as a social response to the view that retarded persons were socially unfit and inferior beings.

The beginning was grounded in benign motives and sensible theories. What may have been the first systematic survey of retarded persons was undertaken in 1846 by Dr. Samuel Gridley Howe of Massachusetts. Dr. Howe believed most of the persons he surveyed could be helped by education if given suf-

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[9] In its definition of "institution" the American Association on Mental Deficiency notes that such facilities have "traditionally been separated from the general population." American Association on Mental Deficiency, *Manual on Terminology and Classification in Mental Retardation* 5 (H. Grossman rev. ed. 1977). *See also* E. Goffman, *Asylums* xiii (1961).

The Laconia State School in New Hampshire was opened in 1903 and was first known as the New Hampshire School for the Feeble-Minded Children. 1901 N.H. Laws. c. 102, § 1. There are currently approximately 560 residents at the school living in buildings which are antiquated in construction and design. One of the defendant's experts stated in a deposition that "[m]ost of the living quarters [are] not suitable for people to live in." *Garrity* v. *Gallen, supra,* (Pls. Ex. 164 for ID at 51-52, 74).

The Northampton State Hospital has served the four western counties of Massachusetts since 1858 when it admitted it first resident. Sarah, a 77 year-old women "suffering her first attack of insanity" was transported 96 miles from her home in Andover to "New Hospital for the Insane in Western Massachusetts" at Northampton. In the 122 years since her admission over 64,500 other persons have been confined at the Northampton State Hospital. J. Geller, "Time For More Debate About Hospital," Hampshire Gazette, June 26, 1980 at 6, col. 3. By December 1976, the date of the filing of the complaint in *Brewster* v. *Dukakis, supra,* the population of the Hospital was about 500 residents. As a result of the consent decree signed in that case, the population had decreased to 257 by August of 1980 through the creation of community residential and nonresidential alternatives to the institution. *Brewster* v. *Dukakis, supra,* Monitor's Report 2 (June 15, 1980).

ficient time, a special school and special modes of instruction.[10] The Masschusetts legislature responded quickly to Dr. Howe's report by creating the first public residential institution for the retarded in America — the Massachusetts School for Idiot Children and Young. Within the next ten years New York, Pennsylvania, Connecticut, Ohio and Kentucky followed this example. The early schools emphasized education, were located near or in the hearts of communities, and the length of stay for students was expected to be short, as some improvement was felt to be a near certainty.[11]

The rapid development of asylums, with their promises of habilitation and treatment, was followed by a second phase of society's response to retardation. The early institutions for the retarded had failed to achieve even their minimal goals — many residents did not return to their families and their communities and xenophobic reactions fundamentally altered the types of people sent to institutions.[12] Such results were not compatible with the promises of quick and complete improvement. The response of public officials was to change the pur-

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[10] President's Committee on Mental Retardation, *Past and Present* 3 (1976).

[11] Wolfensberger, *The Origin and Nature of Our Institutional Models, reprinted from* President's Committee on Mental Retardation, *Changing Patterns in Residential Services for the Mentally Retarded* 31-34 (1969). During the nineteenth century institutions for the mentally ill were also established for many of the same reasons as those which gave rise to facilities for retarded persons. D. Rothman, *The Discovery of the Asylum* 130-131 (1971).

[12] Wolfensberger, *supra* note 11, at 37. The claims of the caretakers of the "insane" likewise came under attack in the mid and late nineteenth century. "Lunatic asylums" began to swell with a long-term and increasingly immigrant population. By 1864 the patient population of the Taunton (Massachusetts) State Hospital was nearly fifty percent Irish immigrants. Worcester Lunatic Hospital, *Eighteenth Annual Report* 41 *cited in* D. Rothman, *supra* note 11, at 283, 361n. 38. Walter E. Fernald, initially disagreeing with the view that a few years of institutionalization would prepare a retarded person to return home, asked: "What is to be done with the feeble-minded progeny of the foreign hordes that have settled and are settling among us?" P. Tyor, *Segregation or Surgery: The Mentally Retarded in America* 160 (1972).

pose of institutionalization from education and treatment to protection. By the 1880s the transformation in purpose was complete.[13]

Basically, protection meant isolation. Institutions quickly moved from the cities to more rural locations. Predictably, they also grew in size as it seemed more administratively convenient to provide custodial, protective care on a large scale to many residents at one time without regard to their individual strengths or needs.[14] By the turn of the century yet another negative stereotype had emerged: the retarded were beginning to be viewed as a "social menace" and associated with juvenile delinquency, crime, foreigners and other "social evils."[15]

Although this misguided generalization has been fully repudiated by government officials and professionals,[16] the states have been slow to abandon the substantial investments, both financial and philosophical, they made in institutions.[17] The result has been a reluctance to shift resources from the institution to community alternatives, and thus a continuing need to maintain the institution in some form.[18] As a result of inertia, institutions have provided a convenient, if expensive,[19] response to society's distaste for its retarded citizens.

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[13] Menolascino, *Challenges in Mental Retardation* 46 (1977).

[14] Wolfensberger, *supra* note 11, at 40-1. *See* S. Herr, *Legal Protection for Residents of Institutions for the Mentally Handicapped in New York* 57-58 (1979) (unpublished D. Phil. thesis in Harvard Law School Library).

[15] Wolfensberger, *supra* note 11, at 45-46. To counter the chance of a spread of retardation and its perceived evils, which were believed to be hereditary, the states passed laws restricting the right of a retarded person to marry and requiring sterilization. *Id.* at 54-55. *See*, Note, *Compulsory Sterilization of the Mentally Ill and Retarded: In re Sterilization of Moore*, 30 SW. L.J. 775 (1976).

[16] *See* S. Davies, *Social Control of the Mentally Deficient* 130 (1930).

[17] In New York, for example, until quite recently ninety-five per cent of state retardation expenditures went to inpatient, institutional services. S. Herr, *The New Clients: Legal Services for Mentally Retarded Persons* 41 (1979).

[18] Wolfensberger, *supra* note 11, at 77-78; *See* President's Committee on Mental Retardation, *supra* note 10, at 16.

[19] The Florida legislature has determined that institutions "are unreasonably costly, are ineffective in bringing the individual client to his or her maxi-

B. *Because of the Lack of Community Alternatives, Retarded Persons Are Inappropriately and Unnecessarily Segregated in Institutions Which Are Characterized by Deplorable Conditions, Inadequate Staffing, Excessive Physical and Mechanical Restraint, and an Environment Which Prevents Rather than Promotes Habilitation and Treatment.*

Mental institutions share not only a common past but a common present as well. The "abominable conditions to which Pennhurst residents have been subjected," *Halderman* v. *Pennhurst*, 612 F.2d at 92, are typical of most, if not all, public institutions for the disabled.[20] Thousands of handicapped citizens have been inappropriately and unnecessarily placed in such "abominable" facilities due to the lack of adequate community alternatives.[21]

Moreover, the population of institutions for the disabled includes a disproportionate percentage of traditionally powerless groups like the elderly, the young, the poor, minorities, and the more severely handicapped. *See NYSARC* v. *Rockefeller*,

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mum potential, and are in fact debilitating to a great majority of clients." Fla. Stat. Ann. § 393.062 (West Supp. 1978).

[20] In 1977 the American Psychiatric Association stated that mentally disabled people in large and remote institutions are provided "mere custody in an environment that does not even allow a minimum level of humane care." American Psychiatric Association, Task Force on the Right to Treatment, *Position Statement on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded, reprinted in* 134 Am. J. Psych. 354, 354 (1977).

[21] *See, e.g., Miss Nelson, 103 Dies: Confined for a Century*, New York Times, Feb. 1, 1974, at 30, col. 2 (committed for an unknown reason at age 4, Martha Nelson was institutionalized for almost a century and no one knew why). Recently, at a Senior Citizens' Week celebration at the Wrentham State School in Massachusetts, the oldest resident was identified as an eighty-four year-old man who had been institutionalized for sixty-one years. The man was orginally committed to the school because someone feared "he might get into trouble in the community." In view of the Wrentham staff, the man is not now nor ever was retarded. Conversation with Francis Kelley, Superintendent of the Wrentham State School, September 4, 1980.

357 F. Supp. 752, 755 (E.D.N.Y. 1973). The special needs of these disabled citizens are routinely ignored in institutions. Because massive facilities demand regimentation and routine, individual differences are subordinated to the requirements of the larger group. Residents with needs related to their race, cultural background, or handicap suffer doubly from the institution's inadequacies.[22]

Mental institutions are also characterized by grossly underpaid, untrained, and insufficient staff. *Wyatt* v. *Stickney*, 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *Welsch* v. *Likins*, 373 F. Supp. 487 (D.Minn. 1974), *aff'd in part and remanded in part*, 550 F.2d 1122 (8th Cir. 1977); *Davis* v. *Watkins*, 384 F. Supp. 1196 (N.D. Ohio 1974); *Evans* v. *Washington*, 459 F. Supp. 483 (D.D.C. 1978). The *Wyatt* court found that there was only one physician for every 550 residents at the Partlow School and only two of the four physicians were licensed to practice medicine in Alabama. Similar conditions have been found at most other institutions for the retarded.[23]

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[22] As the Special Master in *Wuori* v. *Zitnay*, *supra*, wrote:

> Most, but by no means all, of the residents of Pineland are severely or profoundly retarded. They have varying capabilities for accepting education. Many are multiply handicapped, suffering blindness, deafness, mental illness, susceptibility to seizures, and physical abnormalities. Many have behavioral problems of aggression or self-abuse. Some suffer in ways which even the experts cannot comprehend. But, with rare exception, they suffer most from the failure to appreciate their affirmative capabilities. They have doubly suffered who have endured years of neglect of their intellectual and physical capacities.

Report of Special Master 2 (March 19, 1979).

[23] At the Fircrest School in Washington, a special review team found the overall number of staff "grossly insufficient," the availability of professional services "rang[ing] from very limited to nonexistent," and staff development opportunities "limited or unavailable." The team concluded that "[b]ecause of the lack of sufficient numbers of resources, the staff can provide little more than basic custodial services." J. Hollis, P. McNelly, W. Jones, *Special Team Report: Visits to the Y Buildings and Madarona Building at Fircrest School* 3-4 (1980). The Laconia State School in New Hampshire has no medical di-

Even where state officials have recognized the serious deficiencies in the staffing and quality of care rendered at these institutions and have entered into consent decrees providing that staffing patterns become and remain adequate, *e.g.*, *NYSARC* v. *Carey*, *supra*, (Consent Decree, App. A, Sec. C); *MARC* v. *Dukakis*, *supra*, (Personnel Decrees, Aug. 2, 1978), there has been little success in recruiting qualified staff or improving the care at these facilities.[24] In fact, little more than custodial care can ever be provided to residents in institutions. This realization led the District Court below to follow the lead of legislatures, executive officials, and mental retardation professionals and conclude that safe and decent care can rarely, if ever, be provided within a massive state institution. *Halderman* v. *Pennhurst*, 446 F. Supp. at 1318.

Among the most restrictive and harmful conditions in institutions are the extensive use of physical, chemical and mechanical means to bind and restrain residents and the use of seclusion to segregate them in small, barren cells. *Halderman* v. *Pennhurst*, 612 F.2d at 93, 108; *Wyatt* v. *Stickney*, 344 F. Supp. at 380. Studies of these drastic interventions have concluded that they are overused, poorly monitored and employed on a routine basis.[25] Judicial decisions have likewise

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rector and chronic nursing vacancies. *Garrity* v. *Gallen*, *supra*, (Test. of Crocker, Talley; Defs.' Ex. 202). Vacancies in professional and direct care staff have resulted in the school being unable to provide individual services to residents or have forced the termination of such services. (Defs.' Admissions, p. 6.)

[24] One court official who oversees all aspects of a comprehensive remedial plan and has struggled continuously with this problem noted: "Employee recruitment and retention has become the most troublesome impediment to full implementation of the consent decrees." *MARC* v. *Dukakis*, *supra*, Report to the Court 39 (June 1979.)

[25] The Juvenile Justice Committee of the West Virginia Supreme Court of Appeals recently visited the Colin Anderson Center and reported that in one building the residents were kept in "cribs" which are "large cages with metal bars on all four sides confining a small mattress." The Committee was told that residents are kept in the cage-cribs most of the day and reported that "[a]n infant male . . . was permitted out of his crib for only two hours per day. [The Committee] observed a small girl learning to walk by moving up-

demonstrated the extent to which they are abused — often as a behavior control device made necessary because of insufficient staffing. *Rogers* v. *Okin*, 478 F. Supp. 1342, 1367-80 (D. Mass. 1979); *Welsch* v. *Likins*, 373 F. Supp. at 503. Every resident lives with the likelihood of such violence as part of his daily existence.[26]

Finally, even when not locked up or drugged, the fundamental rights of retarded persons are inevitably affected by their institutionalization.[27] *Baxtrom* v. *Herold*, 383 U.S. 107, 113 (1966). Residents in institutions live rigid, structured lives, governed by the needs of the facility and subject, in almost all their actions, to the discretion and control of the staff. *Parham* v. *J.R.*, 442 U.S. 584, 626 (1979) (Brennan J., dissenting).

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right around her cage. . . . Discussions with aides indicated that patients are not encouraged to walk. In fact, [the Committee] was left with the impression that walking is discouraged since a 'walker' is more difficult to control than a non-mobile resident. Patients who walk too much, it appeared, would be confined to their cages until 'broken' of this habit." *Interim Report on the Colin Anderson Center* 6-7 (1980). *See also* Plotkin and Gill, *Invisible Manacles: Drugging Mentally Retarded People*, 31 Stan. L. Rev. 637 (1979).

[26] For instance, an official survey in Kentucky noted that during one ten-month period, 125,739 hours of restraint and seclusion of Outwood residents was recorded. The reporters observed one nude resident tied to a toilet seat. *KARC* v. *Conn, supra*, (Pl's Ex. 85 at 171, 179) (Report of Kentucky Division of Licensing and Regulation, 1977). Witnesses at the trial testified to observing another resident tied to a radiator, sitting in his own urine. (Test. of Elkin at 414-15; Gossick at 87).

[27] Residents are traditionally deprived of their rights of liberty, privacy, association and travel. Also frequently curtailed are their rights to freely practice their religion, to communicate, to be free of unreasonable searches, to control their property, to due process, and to consent to medical treatment. *See generally* Ferleger, *Loosing the Chains: In-Hospital Civil Liberties of Mental Patients*, 13 Santa Clara Lawyer 447 (1973); *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1316-1372 (1974).

C. *The Environment of a Public Mental Institution Has Profound and Adverse Effects on its Residents.*

The realities of institutional life inevitably take their toll on the residents. Institutionalized people suffer and sometimes die from physical abuse, *Wyatt* v. *Aderholt*, 503 F.2d at 1311; *Halderman* v. *Pennhurst*, 612 F.2d at 92-3; their behavior and skills regress, *Id.;* they bear the stigma of having been in an institution, *Parham* v. *J.R.*, 442 U.S. at 601; and, perhaps most tragically, as their potential for growth is smothered, they become passive, vegetative and dependent upon the institution. *See* E. Goffman, *Asylums* (1961).

The court below concluded that the environment at Pennhurst is actually "hazardous to residents, both physically and psychologically." 612 F.2d at 108. It found unsanitary conditions, urine and excrement on the floors, commonplace infectious diseases, excessive noise, and obnoxious odors. It even discovered that some residents suffered from serious injuries, inflicted by staff members, including sexual assaults. 612 F.2d at 92-3. Litanies of physical harm and death appear throughout the reported cases. *See, e.g., NYSARC* v. *Rockefeller*, 357 F. Supp. at 756 (finding that the "inhumane" conditions at Willowbrook, including the "failure to protect the physical safety of [the] children," resulted in "the loss of an eye, the breaking of teeth, the loss of part of an ear bitten off by another resident, and frequent bruises and scalp wounds"); *Wyatt* v. *Aderholt*, 503 F.2d at 1311 (four Partlow residents died due to lack of supervision, understaffing and brutality: one when a garden hose was inserted into his rectum, one after being hosed with scalding water, one after soapy water was forced into his mouth, and one by self-administered overdoses of inadequately secured drugs).[28]

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[28] Courts are frequently confronted with the shocking realities of institutional conditions at trial. A nurse at a local hospital testified that a Willowbrook resident was brought to the hospital to have a broken leg set and, thereafter, returned to Willowbrook. When next brought to the hospital his cast was soaked with urine and, when opened, contained bugs and

Confining the retarded to large, impersonal institutions actually leads to a deterioration in their behavior and functioning rather than to an improvement. In concluding that most institutional environments have an adverse effect on residents, one commentator recently observed:

> Testimony shows that residents who once spoke, stop speaking; that residents who once walked, stop walking. In short, people lose their skills for self-help and autonomy. The impersonal care of the institution produces detached, often bizarre, sometimes self-destructive behavior. Residents' tested intelligence declines.

S. Herr, *supra* note 18, at 29. The Court of Appeals specifically noted that the residents of Pennhurst suffered physical deterioration and intellectual and behavioral regression while in the institution. 612 F.2d at 93. Describing the conditions at Pineland Center, the Special Master recently wrote:

> What most of us did not know was what happened to the mentally retarded after they were committed to the state's care. Essentially they were kept. They were kept clean, kept safe, kept confined, kept bed-ridden, kept in strait jackets and camisoles, kept away from attractive things, and kept away from us. Even so, they were not

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maggots. *NYSARC* v. *Rockefeller*, *supra*, (Test. of J. Hutter, Oct. 7, 1974). An employee of a facility to which Willowbrook residents had been transferred testified to the routine use of cattle prods on residents. (Test. of R. Rubin, Oct. 2, 1974). Witnesses in *KARC* v. *Conn*, *supra*, told of a plaintiff suffering from loss of the full use of his fingers because of a compound fracture suffered at Outwood (Test. of Christian 1574-76); of a supervisor observed repeatedly slamming a resident's face against the table in the dining room (Pls.' Ex. 100 (b)); and of 304 serious reported incidents in a two year period for which residents required medical treatment. Each of the cases in which Amici have participated present similar facts and not surprisingly, most courts have reached a similar conclusion — that retarded people are being denied their right to adequate habilitation in the least restrictive environment.

> well-kept. Their care was based on a second principle of the philosophy now abandoned: that persons who are mentally retarded are incapable of learning, of growing, of having normal human experiences, of taking care of themselves, and of contributing to society. Under these conditions a person's faculties not only fail to develop to their potential but also are likely to deteriorate. The present effects of these now-abandoned practices are currently observable at Pineland Center.

Wuori v. *Zitnay, supra,* Report of Special Master 2 (March 19, 1979).

II. Federal and State Statutes and Policies Reflect a Clear Mandate to Create a System of Less Restrictive Community Programs for Disabled Persons.

A. *The Governing Federal Statutory Programs Are Designed to Encourage the Development of Community Alternatives to Institutions.*

Almost two decades ago Congress embarked on a new approach to the care and treatment of disabled persons. "This new approach involved starting a series of programs to stimulate and support an array of community services as alternatives to institutional care, which enable mentally disabled persons to remain in or return to their communities and to be as independent and self-supporting as possible." *Report to the Congress* at 1. The approach was not limited to a single statutory program but instead was incorporated in a broad array of legislation, including the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000 *et seq.* (DD Act); Title XX of the Social Security Act, 42 U.S.C. § 1397 (Title XX); the Rehabilitation Act of 1973, 29 U.S.C. § 701, (Section 504); the Education for All Handicapped Act, 20 U.S.C. § 1401 (Education Act); and the Community Mental

Health Centers Act, 42 U.S.C. § 2689, (CMHC Act). Although Amici do not address in detail the threshold question of whether the DD Act establishes a particular substantive right, these federal programs represent a legislative judgment to create less restrictive community services in order to put an end to any federal support of the unnecessary and inappropriate institutionalization of retarded citizens.

1. The DD Act, through its legislative history, expresses an intention to establish community services.

In enacting the DD Act the Congress specifically found that:

> [I]t is in the national interest to strengthen specific programs, especially programs that reduce or eliminate the need for institutional care, [in order] to meet the needs of persons with developmental disabilities.

42 U.S.C. § 6000(a)(5). The articulation of this legislative purpose was the result of extensive hearings over several years during which Congress recognized that abuses in the care of retarded persons were commonplace, including "inappropriate admissions [to institutions] because of a lack of community services." 121 Cong. Rec. 16,516-17 (June 2, 1975) (Comments of Sen. Williams). To remedy this glaring deficiency the Act directed that at least sixty-five per cent of state allotments be spent on community services. 42 U.S.C. § 6063(b)(3)(B).

The legislative history of the DD Act leaves little doubt that beneath the specific intention to provide federal support to a comprehensive system of community alternatives lay the general concern that retarded persons should be treated as equal citizens and not segregated through an isolated institutional delivery system. H.R. Rep. No. 1188, 95th Cong., 2d Sess. *reprinted in* [1978] U.S. Code Cong. and Ad. News 7533, 7539-40. The Senate's consideration of the Act was based on its finding that:

> [C]ongress must take action to ensure the humane care, treatment, habilitation, and protection of the mentally retarded. The Federal Government has the responsibility to provide equal protection under the law to all citizens.

S. Rep. No. 160, 94th Cong., 1st Sess. at 32;

While the Congress acknowledged the reality that until community services were fully available for retarded persons, institutions would have to remain in some form, it declared straightforwardly that all services must be provided "in the setting that is least restrictive of the person's personal liberty." 42 U.S.C. § 6010(2); S. Rep. 160, *supra*, at 32-33. Thus the DD Act represents a fundamental Congressional judgment that federal funds should only be used to provide less restrictive alternatives for retarded citizens.

2. Title XX of the Social Security Act provides additional nonresidential support services to prevent or reduce inappropriate institutionalization.

The enabling legislation for Title XX authorized appropriations to encourage each state to furnish social services to its needy citizens pursuant to five explicit goals, one of which included "preventing or reducing inappropriate institutional care by providing for community-based care, or other forms of less intensive care." 42 U.S.C. § 1397(4). The legislative history and implementing regulations make clear that federal funds are to be used to encourage "development of safe and appropriate residential settings as an alternative to institutional living for appropriate elderly individuals and handicapped children and adults . . . ." 43 Fed. Reg. 4016 (1978). Thus Congress has determined that, in restructuring its major social services funding program, preventing institutionalization through community support systems is one of its highest priorities.

3. The Rehabilitation Act of 1973 is the major civil rights law for handicapped citizens requiring equal and accessible community services for the retarded.

Using similar language to Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d, the Congress has declared that handicapped persons can no longer be subject to separate and unequal treatment by facilities or organizations which enjoy any federal benefits. *See* 29 U.S.C. § 794, as amended. Both the legislative history of Section 504 and its implementing regulations prohibit the continued segregation of the handicapped and require instead that services and activities for them be provided in normalized and integrated settings. Discrimination between and among handicapped persons on the basis of the severity of their disability is likewise prohibited. 42 Fed. Reg. 22,676 (1977).

Senator Humphrey, the bill's primary sponsor in the Senate, noted the basic purpose of Section 504:

> [T]he fundamental fact that one confronts is . . . the segregation of millions of Americans from society — suggesting a disturbing viewpoint that these people are not only forgotten but perhaps expendable.

118 Cong. Rec. S9495 (March 22, 1972). In mandating equal and accessible services for the handicapped, Congress recognized that traditionally institutions were the primary mechanism utilized by society to segregate retarded persons. The remedy to this historical neglect was to be decent services in open, community settings. Senator Humphrey said:

> I am calling for public attention to three-fourths of the Nation's institutionalized mentally retarded, who live in public and private residential facilities which are more than 50 years old, functionally inadequate, and designed simply to isolate these persons from society.
>
> These people have the right to live, to work to the best of their ability — to know the dignity to which every

> human being is entitled. But too often we keep children, whom we regard as "different" or a "disturbing influence," out of our schools and community activities altogether . . . . Where is the cost-effectiveness in consigning them to "terminal" care in an institution?

118 Cong. Rec. S525 (Jan 20, 1972). Congress, in declaring that the handicapped are to be treated as equal citizens, enacted yet another legislative directive requiring that the retarded be cared for in their communities.

4. The Education for All Handicapped Act requires integrated community educational programs for all retarded children.

In response to the landmark decisions in *Pennsylvania Association for Retarded Citizens* v. *Pennsylvania*, 343 F. Supp. 279 (E.D. Pa. 1972) and *Mills* v. *Board of Education*, 348 F. Supp. 866 (D.D.C. 1972), in which the lower courts recognized that all mentally retarded children can benefit from a formal program of education and training, the Congress enacted the Education for All Handicapped Act of 1975, 20 U.S.C. § 1401. The legislation broadly mandates that all handicapped children be provided with a "free, appropriate public education and related services designed to meet their needs." *Id.* The Act further requires that each child's educational program be provided in a setting which is both integrated and the least restrictive possible in order to ensure:

> [T]hat to the maximum extent appropriate, handicapped children, including children in public or private institutions or other care facilities, are educated with children who are not handicapped . . . .

45 C.F.R. § 121a.550. *See* 20 U.S.C. § 1412(5)(B).

Given the recognized detriments of educating children in isolated or culturally segregated settings, *Milliken* v. *Bradley*, 433 U.S. 267 (1977), the Congress acted to prevent further un-

necessary institutionalization of the retarded and to increase the likelihood that presently institutionalized persons could one day become productive citizens. *See* S. Rep. No. 94-168, 94th Cong., 1st Sess. *reprinted in* [1975] U.S. Code Cong. and Ad. News 1433. The Education Act represents yet another example of the legislative judgment that retarded persons can no longer be segregated and denied the same opportunities to learn and grow as are available to other citizens.

5. The Community Mental Health Centers Act establishes a network of federally supported community services as an alternative to state institutions.

The Community Mental Health Centers Act, 42 U.S.C. § 2689, was originally enacted to encourage states, through limited "seed money," to create comprehensive systems of community alternatives to state mental hospitals. Soon this limitation on federal involvement was discarded in favor of fundamental Congressional support for community services. In the 1978 Amendments Congress found that "[C]ommunity mental health care is the most effective and humane form of care for a majority of mentally ill individuals." Pub. L. No. 94-63, § 302(b), *reprinted in* [1978] U.S. Code Cong. and Ad. News 9042, 9048. These amendments also mandate that each center provide a number of essential services, including residential and nonresidential programs for formerly institutionalized persons. 42 U.S.C. § 2689(b)(1).

The legislative history of the CMHC Act discloses the continuing recognition that:

> [C]ommunity settings with supportive services would facilitate the capability of . . . clients to live more independent, functional lives and to avoid unnecessary institutionalization.

[1975] U.S. Code Cong. and Ad. News 469, 540. Since 1963 Congress has repeatedly noted the benefits of community care for disabled persons and has not hesitated to provide increased

federal support to mental health centers as the only viable and effective alternative to unnecessary and detrimental institutionalization. *National Council of Community Mental Health Centers, Inc.* v. *Weinberger*, 361 F. Supp. 897 (D.D.C. 1973).

When these five federal statutory programs are taken together, an unmistakable pattern emerges — care and treatment in community programs is not only the preferred alternative to the institutionalization of retarded persons but the primary approach which has received Congressional endorsement. While much of the promise of these legislative pronouncements remains unfulfilled, *Report to the Congress* at i-x, the mandate to create an integrated network of community alternatives is unmistakable.

B. *State Statutes and Policies Mandate the Establishment of a System of Community Programs and Require that Retarded Persons Be Treated in Less Restrictive Settings than Institutions.*

Following the lead of the Congress, numerous state legislatures have enacted statutory requirements that retarded persons be provided with adequate services in the least restrictive alternative. The federal initiative, originally incorporated in the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, Pub. L. No. 88-164, 42 U.S.C. § 2689, has led many states to begin to establish comprehensive systems of residential and nonresidential programs based on local administrative structures.

Generally, this effort is the product of a legislative mandate declaring that community services must be created to avoid the unnecessary institutionalization of disabled persons. In addition, executive agencies responsible for the care and treatment of the retarded have extensively documented the need for various residential and support services and have described in detail the necessary steps and resources required to develop such alternatives. While states may differ as to the precise services they should fund, or the most effective adminstrative

mechanism to design, create, or coordinate these community programs, or even the rate at which these services should be initiated, there is virtual unanimity that community alternatives are preferable and necessary to avoid the human and fiscal costs resulting from the historical reliance on institutional care. *See* note 19 *supra*.

1. Numerous state statutes require the creation of a system of community programs as an alternative to institutionalization.

State governments have traditionally relied on massive public institutions to house their handicapped persons. The limitations and tragic consequences of this approach have been convincingly documented by government officials, lower courts, and mental retardation professionals. As local citizens have become increasingly alarmed at the rising costs of institutional care and the inhumane consequences of discharging formerly institutionalized persons to the streets, without adequate support services, public officials have moved gradually to formalize a state policy for community care. This policy has been commonly incorporated in legislation, using broad language to mandate the development of community alternatives to institutionalization:

> Therefore, it shall be the policy of the state . . . to develop a comprehensive, integrated system to serve the full-range of needs of the mentally retarded and developmentally disabled by expanding the numbers and types of community based services and developing new methods of service delivery. . . .

N.Y. Mental Hyg. Law § 1302 (McKinney).

> It is the intent of the Legislature to establish a . . . system of residential treatment programs in every county which provide, in each county, a range of available services which will be alternatives to institutional care and are

> based on principles of residential, community-based treatment.

Calif. Welf. & Inst. Code § 5450 (West).

> The department shall establish a comprehensive program of community mental health and retardation services . . . and shall establish standards for the development of said community programs on area and regional levels.

Mass. Gen. Laws c. 19, § 17 (West). *See also* Colo. Rev. Stat. § 2710.5-101; Ky. Rev. Stat. § 210; Me. Rev. Stat. c. 221, § 2601 and c. 186-A, § 2141; N.H. Rev. Stat. Ann. §§ 171-A:1 *et seq.* and 126-A:39.

Moreover, a majority of the states have recognized the appropriateness and necessity of providing care and treatment in less restrictive community programs, wherever possible, and have incorporated this judgment in their statutory schemes regulating admissions and commitments to public institutions. *See Table of State Statutes* in Brief of Respondent Halderman *et al.*

In jurisdiction after jurisdiction, state legislatures have followed the lead of the Congress by acting affirmatively to end the historical reliance on institutions and to require the creation of community alternatives for retarded persons. Although the shift from institutional to community services is not administratively simple,[29] this judgment, and the entitlements created thereunder for retarded citizens, offer the poten-

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[29] The inertia of institutions has proved to be highly resistant to legislative directives and executive guidelines favoring treatment in the community. *Report to the Congress* at 24. President's Panel on Mental Retardation, *Report to the President* 143 (1962). Recognizing that new service delivery approaches may require new administrative structures to ensure their effectiveness, many state legislatures have formalized their commitment to community care through either the creation of separate agency divisions in each local community or through the use of existing governmental units to develop this system of institutional alternatives. Ky. Rev. Stat. § 210.410(6); N.H. Rev. Stat. Ann. § 171-A: 18; Me. Rev. Stat. c. 223, §§ 2611 & 2643; Mass. Gen. L. c. 19, §§ 17-24.

tial for decent, integrated, and accessible community services to those who have been hidden so long from the public view.

2. State officials have documented the appropriateness of providing care to most institutionalized persons through community programs.

The legislative directives to create a system of community alternatives has been fully supported, at least in theory, by state executive officers.[30] There are literally a myriad of pub-

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[30] This policy was recently articulated by the highest executive official in the Commonwealth of Massachusetts in the following message to the Senate and House of Representatives:

> Reflecting the social attitudes and scientific beliefs of the era, the Commonwealth began in the early 19th century to create asylums and other institutions for those afflicted with a variety of social or health problems. For corrective or therapeutic reasons, these institutions removed people from society and effectively banished them to care in remote locations. Over the past century and a half, the Commonwealth has maintained and increased these institutional services.
>
> The Massachusetts mental health hospital system has been faced with increasing difficulty during recent years. Foremost among these has been the stigma of a segregated state mental health delivery system whose clients have borne the twin burdens of poverty and discrimination due to mental illness. The remote location of many of our state mental hospitals has created problems in recruiting and retaining professional staff. The lack of access to community resources has isolated the clients and removed them from rehabilitative contact with their families and friends. The hospitals' large size has resulted in exhorbitant maintenance and energy costs. The heating costs at Boston State Hospital are now over $12,000 per client for this year and are rising rapidly.
>
> . . . . . .
>
> I believe that [community based] programs have demonstrated their therapeutic merit and efficacy and that they are financially feasible. What is perhaps most important, people have demonstrated a willingness to end the stigma which has for centuries thwarted the rehabilitation of those less fortunate citizens. We have recommitted ourselves to the historic values that people should be free and independent, assisted and maintained, where necessary, in the least restrictive settings consistent with the protection of the public and the individual.

Preamble to House Bill No. 6013, submitted by Governor Edward J. King to the Massachusetts General Court (March 3, 1980).

lic documents produced by a wide variety of state agencies attesting to the pressing need for additional community programs to eliminate the unnecessary confinement of most institutionalized persons. *See, e.g., KARC* v. *Conn., supra,* (Pls.' Ex. 103) (Kentucky Legislative Research Commission, *Society's Stepchildren: The Mentally Retarded,* 1974); Massachusetts Department of Mental Health, *Five Year Plan* (1977); New Hampshire Division of Mental Health, *State Plans (*1978 and 1979); Vermont Department of Mental Health, *Mental Retardation Plan* (1979).

These documents reflect the considered judgment of mental retardation professionals and represent the express policies of each state. While they may differ as to both the specific community programs needed by a particular institutional population or the procedures for creating these programs, there is a remarkable consensus among state officials that most institutionalized persons could be more adequately and less intrusively served in a community care system.[31]

Thus state governments have, in following the initiative of the Congress, adopted a series of statutes and policies to supplement the federal mandate for the development of community alternatives to public institutions. But as long as implementation of this consensus judgment remains limited, *Report to the Congress* at 19-23, its import for the institutionalized is but an unfilled legislative promise.

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[31] Even Pennsylvania has accepted this view, as noted by a dissenting minority of parents. Motion to File Amici Curiae Brief of the Congress of Advocates *et al.*, ¶ 7.

III. Federal Litigation is Necessary to Redress the Continuing Violation of the Rights of the Institutionalized Disabled and to Prevent Further Harm and Deterioration.

A. *The Enactment of Federal and State Legislation and the Formulation of Related Policies Requiring the Development of Community Alternatives Did Little to Improve the Plight of Institutionalized Retarded Citizens.*

Unfortunately, although Congress and state officials had fashioned a policy to respond to the unacceptable consequences of institutionalization, these mandates did not produce any immediate benefit to the hundreds of thousands of citizens confined in those facilities.[32] *Report to the Congress* at i-x. For various reasons these statutory promises were not translated into meaningful realities,[33] thereby leaving retarded citizens to suffer the continuing harms of unnecessary and prolonged institutionalization.[34] In jurisdiction after jurisdiction,

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[32] In Massachusetts, ten years after the passage of the Comprehensive Mental Health and Retardation Services Act (1966 Mass. Acts c. 735, Mass. G.L. c. 19, §§ 17, 24), which required the creation of a broad range of community services for mentally retarded and mentally ill citizens, the Department of Mental Health had barely succeeded in the preliminary task of implementing an administrative framework to design and create this community system. Only a handful of publicly supported programs had been established for disabled persons. The experience with similar statutory requirements in other jurisdictions was no better. *Halderman* v. *Pennhurst, supra*. *See* Coleman and Gilbert, *Stalking the Least Restrictive Alternative* 31 (1979).

[33] Legislative mandates were frequently frustrated by bureaucratic resistance to change, particularly by those in positions of authority in the institution; by the lack of cooperation between governmental agencies; by the absence of systematic planning; and by the absence of administrative directives and guidelines necessary to accomplish any modification of service delivery. *Report to the Congress* at 23-25. *See* L. Bachrach, *Deinstitutionalization: An Analytical Review and Sociological Perspective* (ADM 76-351) (1976).

[34] In Massachusetts the census of the state schools for the retarded only slightly decreased between 1963 and 1974 — the first decade after the General Court enacted its community services legislation. Moreover, many of these persons were simply transferred to large nursing facilities. *Report to*

facility after facility, inertia has resulted in the states' failure to implement the guarantee to minimally adequate care in less restrictive and more normal settings.[35] *Report to the Congress* at 19-21. This recalcitrance violates both legislative and executive directives as well as professionally accepted norms of decent treatment, leaving the institutionalized retarded in the same position they were in prior to the promulgation of these policies.[36]

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the Congress at 11-14. There were still 6,900 retarded persons confined in institutions as of 1975, under conditions which even state officials acknowledged to be inhumane and a public embarrassment. *Id.* (Letter of Jerald L. Stevens, Secretary of the Executive Office of Human Services, April 5, 1976) *included as* App. VII to *Region One Report* 89.

[35] In Kentucky a federal court recently recognized the state statutory right under Ky. Rev. Stat. § 202B to treatment in the least restrictive alternative. *KARC* v. *Conn, supra.* Neither the statute nor the frequent acknowledgment by state officials of the need to develop community services has resulted in any reduction in the number of retarded citizens who are institutionalized in Kentucky. (Pls.' Exs. 103-05, 800-02) (various studies, reports, and plans by the Kentucky Division of Mental Retardation and the legislative Subcommittee on Mental Health Facilities). On the contrary, the number has increased in the past five years. *Id.*

[36] In fact, in some jurisdictions the situation may have worsened. In an apparent attempt to honor legislative mandates, but often in response to the rising costs of maintaining large mental institutions, state agencies undertook a somewhat haphazard program of discharging disabled persons from these facilities into communities, with little or no community-based residential care or support services necessary for their safety and protection. Not surprisingly, the national readmission rate to institutions for the retarded doubled between 1963-1971 and in Massachusetts, it increased by more than ten fold. *Report to the Congress* at 21-3. Since the carefully drawn legislative and executive preference for community alternatives was never intended to focus exclusively on reducing the census of state institutions but rather on creating adequate community programs, these oft-publicized actions were not actually undertaken in furtherance of accepted state policies. The resultant "dumping" of helpless disabled citizens into unfamiliar and sometimes unreceptive neighborhoods did little to further the success of these policies, to say nothing of the quality of life for their intended beneficiaries. *See* Bassuk and Gerson, *Deinstitutionalization and Mental Health Services*, 238 Scientific American 46 (February 1978); *Koenig, P., "The Problem That Can't Be Tranquilized," New York Times* (Magazine) (May 21, 1978); *Deinstitutionalization*, Public Employee (May 1979).

B. *The Invocation of the Federal Judicial Power Was Appropriate and Necessary to Remedy the Violation of Established Federal and State Rights to Adequate Care in Less Restrictive Community Alternatives.*

In this context of continuing harm to disabled persons, through confinement under illegal institutional conditions or discharge to virtually non-existent community support programs, the retarded frequently had to turn to the courts to vindicate their legal rights. All the litigation shared a common theme: the systematic failure to implement established rights and policies favoring community treatment in less restrictive settings had resulted in the unnecessary and prolonged institutionalization of handicapped persons. *E.g., Dixon* v. *Weinberger*, 405 F. Supp. 974 (D.D.C. 1975); *NYSARC* v. *Rockefeller, supra*; *Wuori* v. *Zitnay, supra*; *Brewster* v. *Dukakis, supra*. The plaintiffs sought little more than the enforcement of existing guarantees to minimally adequate care in appropriate, less restrictive alternatives, as set forth in federal and state statutes and policies. Like minority school children before them, *Swann* v. *Charlotte-Mecklenburg Board of Education*, 402 U.S. 1 (1971), they had to rely on the federal courts to redress the historical pattern of illegality which characterized the treatment of the disabled.

In virtually every adjudicated case involving an institution for the retarded, the lower courts found a pervasive pattern of segregated and inhumane conditions in violation of constitutional and statutory guarantees. *Wyatt* v. *Stickney, supra*; *Welsch* v. *Likins, supra*; *Davis* v. *Watkins, supra*; *NYSARC* v. *Rockefeller, supra*; *Saville* v. *Treadway*, 404 F. Supp. 430 (M.D. Tenn. 1974); *Gary W.* v. *State of Louisiana*, 437 F. Supp. 1209 (E.D. La. 1976); *Evans* v. *Washington, supra*; *Halderman* v. *Pennhurst, supra*. *Contra, KARC* v. *Conn, supra*. Regardless of the source of the right, the illegality of much institutional confinement is beyond dispute. *Halderman* v. *Pennhurst*, 612 F.2d at 117 (Seitz, C.J., dissenting).

For federal courts to recognize and redress constitutional and statutory violations is the traditional business of the federal judiciary. *Monroe* v. *Pape*, 365 U.S. 167 (1960); *Hutto* v. *Finney*, 437 U.S. 678 (1978); *Hills* v. *Gautreaux*, 425 U.S. 284 (1976). Thus to the extent that retarded persons are locked in massive state facilities under unconstitutional conditions or in violation of federal statutory rights, considerations of federalism present no barrier to the intervention of federal courts.[37] It was precisely in recognition of this fact that Congress recently enacted legislation authorizing the federal government to initiate legal action to protect the rights of institutionalized persons. P.L. No. 96-247 (May 23, 1980).

These are not cases where the class of persons harmed is speculative, *Rizzo* v. *Goode*, 423 U.S. 362 (1976), where the function involved is totally within the province of the states, *National League of Cities* v. *Usery*, 426 U.S. 833 (1976), or where pending state proceedings countenance judicial restraint, *Younger* v. *Harris*, 401 U.S. 37 (1971). Rather, the confinement of retarded persons in facilities which receive substantial federal financial support, are subject to extensive federal regulation, and are nevertheless being operated in contravention of constitutional guarantees and statutory requirements are appropriate subjects for federal court adjudication. *Halderman* v. *Pennhurst*, 612 F.2d at 92.

Similarly, given the pervasive pattern of illegality found by the courts or acknowledged by state defendants, *e.g.*, *MARC* v. *Dukakis*, *supra*, it can hardly be argued that the judiciary should refrain from ordering remedial action by those agencies responsible for perpetrating such conditions and for failing to implement statutory and governmental policies mandating community services. No doctrine of restraint has ever been held to justify judicial sanctioning, through inaction, of executive independence in violation of an individual's established constitutional or statutory rights. *United States* v. *Nix-*

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[37] Even the petitioners and supporting amici concede this to some extent. *See* Amici Curiae Brief of Illinois *et al.* 2; Brief of Petitioners, note 18.

on, 418 U.S. 683 (1974). Courts have traditionally mandated actions by local boards of education, *e.g.*, *Milliken* v. *Bradley*, *supra*; housing authorities, *e.g.*, *Hills* v. *Gautreaux*, *supra*; welfare departments, *e.g.*, *Quern* v. *Jordan*, 440 U.S. 332 (1979); electoral commissions, *e.g.*, *Baker* v. *Carr*, 369 U.S. 186 (1962); prison authorities, *e.g.*, *Procunier* v. *Martinez*, 416 U.S. 396 (1974); and civil service commissions, *e.g.*, *Elrod* v. *Burns*, 427 U.S. 347 (1976) whenever federal rights have been abrogated. *See* Dorsen, *Separation of Powers and Federalism: Two Doctrines With a Common Goal*, 41 Albany L. Rev. 53 (1977).

Moreover, retarded citizens are a discrete and insular minority who have little ability to affect the political process and often are even denied their right to vote. *See Boyd* v. *Registrars of Belchertown*, 368 Mass. 631, 334 N.E.2d 629 (1975). While attention need be paid to the scope of the judicial remedy in order to foster the necessary cooperation for securing the full vindication of the rights in question, the appropriateness of federal adjudication of federal and pendent state law questions cannot be disputed. Where, as here, retarded persons are denied the opportunity to live in decent residential environments in their home communities and instead are needlessly confined under inhumane conditions in large state institutions — all in contravention of a range of federal and state guarantees mandating a system of community support programs — federal court intervention is both appropriate and essential.

C. *The Judicial Enforcement of the Right to Adequate Care in Less Restrictive Community Alternatives Has Expedited the Implementation of State Policies Favoring the Development of Community Programs.*

The federal suits filed to redress the persistent violations of the right to adequate care in less restrictive, community programs have produced a significant improvement in the conditions under which retarded persons are provided publicly funded care and habilitation. In many states these suits have

served to publicize the deplorable conditions in institutions for the retarded and to galvanize the necessary commitments to begin the task of establishing community alternatives. *See, e.g., Wyatt* v. *Stickney, supra*; *NYSARC* v. *Rockefeller, supra*. In most jurisdictions this task is already an accepted, if not required, governmental responsibility. Therefore, federal suits are usually in the nature of enforcement actions, with the argument, if any, focusing on how to implement an acknowledged mandate rather than whether such a policy consensus exists or should exist. *Halderman* v. *Pennhurst*, 612 F.2d at 93; *NYSARC* v. *Carey, supra*; *MARC* v. *Dukakis, supra*; *Brewster* v. *Dukakis, supra*.

Not surprisingly, many of these suits have resulted in consent decrees whereby state defendants have acknowledged not only the desirability but also the legal appropriateness of developing community alternatives to institutions. *NYSARC* v. *Carey, supra*; *Horacek* v. *Exon*, 357 F. Supp. 71 (D. Neb. Consent Decree Oct. 31, 1975); *Sidles* v. *Delaney*, C.A. C75-200A (N.D. Ohio, Consent Decree Apr. 26, 1976); *Doe* v. *Hudspeth*, C.A. J. 75-36(N) (S.D. Miss., Consent Decree Feb. 19, 1977); *Wuori* v. *Zitnay, supra*; *Brewster* v. *Dukakis, supra*; *MARC* v. *Dukakis, supra*; *Michigan ARC* v. *Smith, supra*; *Evans* v. *Washington, supra*; *Dixon* v. *Harris*, C.A. 74-285 (D.D.C, Consent Decree April 30, 1980).

Such judgments not only reflect the consensus among the parties as to the appropriate direction for basic services to retarded persons but also provide a constructive partnership for the development of legally adequate community programs. In fact, many of these negotiated settlements have already produced the plan for, and the first few steps of, a comprehensive remedy. *NYSARC* v. *Carey, supra*; *Wuori* v. *Zitnay, supra*; *Brewster* v. *Dukakis, supra*; *MARC* v. *Dukakis, supra*; *Michigan ARC* v. *Smith, supra*. Thus at least for a portion of the institutionalized retarded, their guarantee of adequate care in the least restrictive alternative is finally being translated into a visible reality.

The emerging community system jointly designed by all the parties is comprised of three components. Community residences and living arrangements integrated into local neighborhoods represent the basic environments in which retarded persons can live free of the stigma and inhumanity of institutional warehouses.[38] Nonresidential habilitation and support services provide the daily education, training and treatment programs which many persons need to assist them in gaining their independence and becoming self-sufficient, productive members of society.[39] Finally, administrative offices design, coordinate, manage, license and monitor this network of community programs.[40]

Community services are built upon the concept of individualized program planning which parallels the Congressional approaches to special education and vocational pro-

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[38] These settings include group homes, apartments, family care situations, intermediate care facilities, and other residential environments with various levels of structure and support. Each is designed to be as homelike and normal as possible with kitchen, bedroom, and common spaces which respect individuals' rights to privacy, personal choice, and dignity. *See, e.g., Brewster* v. *Dukakis, supra* (Att. B); *MARC* v. *Dukakis, supra* (Community Plan, App. D); *Wuori* v. *Zitnay, supra* (App. B, Sec. F). *See also* President's Commission on Mental Retardation, *Mental Retardation: The Known and the Unknown* (DHEW No. (OHD) 76-21008); C. Cherrington and G. Dybwad (eds.), *New Neighbors: Retarded Citizens in Quest of a Home* (1974).

[39] These programs include, among others, clinical assessment, community service coordination, day habilitation, prevocational and work training, respite care, crisis intervention services, and special education. *See, e.g., MARC* v. *Dukakis, supra* (Community Plan, App. I), *Brewster* v. *Dukakis, supra* (Att. C); *Wuori* v. *Zitnay, supra* (App. B, Sec. D). Without these daily activities retarded persons in the community would receive no treatment or training and would be relegated to a life of watching television and wandering the streets, thus reinforcing the previous practices of dumping formerly institutionalized persons into unreceptive and inadequately prepared neighborhoods.

[40] These management functions are the critical link to ensuring that disabled clients are not abandoned and commonly programs are held accountable as part of a complex network of geographically dispersed services. *See, e.g., MARC* v. *Dukakis, supra* (Community Plan, App. E); *Brewster* v. *Dukakis, supra* (Att. F); *Wuori* v. *Zitnay, supra* (App. B, Sec. C).

grams. *See* 20 U.S.C. § 1401 (19) and 29 U.S.C. § 722.[41] Individualized plans not only help match the development of community programs to the persons which they serve, thereby avoiding the impersonal regimentation of institutional care, but also provide a dynamic mechanism to ensure that clients are not forgotten and instead receive periodic reviews of their progress toward more independent living. Some decrees also make special provisions for the training and reallocation of institutional staff into the community,[42] and for standards governing quality of care and clients' legal rights in community programs.[43] Most leave the specification of implementation details and the responsibility for actually accomplishing the promise of the federal court order to the relevant state agencies with authority over the mental retardation or mental health system. *NYSARC* v. *Carey, supra* (Consent Decree, Part V); *Brewster* v. *Dukakis, supra* (¶ 49). But in all cases where implementation of an agreed upon remedy has in fact begun, community alternatives are emerging, which, for the first time in almost a century, present the potential for a safe, decent, and humane environment where retarded people can actually grow rather than regress.

D. *The Development of Community Programs Has Already Had a Significant, Positive Effect on the Quality of the Lives of Formerly Institutionalized Persons.*

For retarded persons who often have been confined for decades in state institutions, the transition to new homes in their original communities is sometimes a difficult but always

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[41] Most judicially approved settlements require individual service plans. *See, e.g., NYSARC* v. *Carey, supra*; *Brewster* v. *Dukakis, supra* (¶¶ 26-30); *Welsch* v. *Dirkswager*, C.A. No. 4-72 C. 451 (D. Minn., Consent Decree Dec. 1977).

[42] *See, e.g., NYSARC* v. *Carey, supra* (App. A, Pt. E); *Brewster* v. *Dukakis, supra* (¶¶ 34-37).

[43] *See, e.g., Brewster* v. *Dukakis, supra* (¶ 32); *Wuori* v. *Zitnay, supra* (App. B, Secs. F, G); *NYSARC* v. *Carey, supra*. *See also* 104 Code of Massachusetts Reuulations (C.M.R.) 20.00 for regulations governing community residential and nonresidential care for retarded persons in Massachusetts.

a unique and humanizing experience. Even within the few years since court approved settlements establishing community programs have been in effect, there is already documented improvement in the lives of thousands of retarded citizens. Evaluations by consultants and reports of court-appointed monitors emphasize the substantial benefit these cases have had for formerly institutionalized persons. *MARC* v. *Dukakis, supra*, Report to the Court (Dec. 1979).

Of the 5000 class members at Willowbrook, more than 1500 have already been successfully placed in small community living arrangements of no more than ten persons. Many of these former state school residents are severely and profoundly retarded. They are personally supported by an extensive network of case managers to monitor their needs and assist them in obtaining appropriate services. By all reports, including studies conducted by state officials and the Willowbrook Review Panel, the residents are thriving in their new homes. This conclusion is fully supported by an observation of the Special Master in *Wuori* v. *Zitnay, supra*:

> Nearly the full promise of the Court's decree is now being realized by clients living in new group homes and participating in new day-activity and work programs. They live in attractive, substantial, noninstitutional group homes. Their lives are active and filled with opportunities to learn. Persons running the new homes and programs tend to be concerned for their clients and share the philosophy of self-sufficiency and independence which underlie the decree. They are working diligently to help people help themselves. Anyone who may entertain doubts about the worth of the undertaking represented by the Court's decree must see the new group homes and programs.

Report of the Special Master 9 (March 19, 1979). A similar theme was echoed by the Monitor in *Brewster* v. *Dukakis, supra*:

> Almost universally, these residential sites, with support from day treatment, day activity or vocational programs, constitute a vastly improved environment for the client.

Monitor's Report 6 (June 15, 1980).

The opportunity to live outside a large institution is perhaps the most dramatic and immediate gain from these decrees. Returning home, near to families and friends, free from the regimentation of institutional life, retarded citizens have the potential to reestablish relationships and achieve a degree of independent living which were denied to them for so long. Beyond that, they learn to use the same services available to non-disabled people, such as transportation, legal, medical, recreation and religious facilities, thereby encouraging their integration into the rhythm of community life and avoiding the expense of establishing entirely separate services for the handicapped. *See* R. Flynn and K. Nitsch (eds.), *Normalization, Social Integration and Community Services* (1980).

Finally, clear evidence is now available that life in normalized community settings increases the independence and productivity of handicapped citizens at costs less than required to maintain these individuals in institutions. *See Report to the Congress* at 5-6; *Service Integration of Deinstitutionalization Project (SID) Report*, Vol. 5 (Cost/Benefit Analysis) (DHEW) (1975). Retarded persons who have suffered the regressive effects of compulsory institutionalization now enjoy the freedom to select their own lunch menu, to choose their own roommate, and to buy their own clothes.[44] From this exercise in self-determination has come a predictable gain in independence,[45] as well as the ability to enjoy the fundamental free-

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[44] Often these rights of self-determination are specifically promulgated in agency policy or regulation. *See* 104 C.M.R. 20.00 (mentally retarded) and 104 C.M.R. 14.00 (mentally ill) which are incorporated by reference in *MARC* v. *Dukakis*, *supra* (¶ 61) and *Brewster* v. *Dukakis*, *supra* (¶ 32).

[45] *See Report to the Congress* at 16-18; D. Braddock, *Opening Closed Doors: The Deinstitutionalization of Disabled Individuals* 99 (Council for Exceptional Children 1977).

doms of citizenship. *See* Herr, *The New Clients*, 31 Stan. L. Rev. 563 (1979). As one court official noted:

> In general, the new residential programs appear to be of good quality and clearly offer the resident an improved environment over the [institution]. Countless examples, discussed or personally witnessed during trips to the residential and non-residential programs, could attest to the new opportunities being offered to mentally ill and mentally retarded persons in these programs. Individuals forgotten for decades in the hospital are now receiving services in a profoundly moving way. Persons who could not communicate are now communicating; persons who could not walk or feed themselves are now ambulatory and are not only feeding themselves, but planning meals, assisting in the purchase and preparation of food and participating in the management of their own daily lives for the first time.

Brewster v. *Dukakis, supra*, Monitor's Report (Aug. 31, 1979).

E. *Judicial Supervision of the Implementation of Consent Decrees and Orders Providing for the Creation of Less Restrictive Community Alternatives Is a Necessary and Apppropriate Exercise of a Court's Equitable Powers.*

Given both the historical failure of states to implement established statutory policies favoring community programs for the retarded and the inherent complexity of creating alternatives to institutional care, experience has demonstrated that some mechanism must be established by district courts to oversee the implementation of their orders so as to enforce the statutory and constitutional rights of retarded plaintiffs. *NYSARC* v. *Carey, supra*; *Wuori* v. *Zitnay, supra*. *See* Note, *Implementation Problems in Institutional Reform Litigation*, 91 Harv. L. Rev. 428 (1977). Although courts have employed a

variety of approaches to provide this assistance,[46] these mechanisms share similar functions. Each is the primary resource for gathering unbiased data to inform the court of the status of the implementation of its order.[47] Each reviews and analyzes the defendants' specific plans for implementing their general obligations under the order and advises the court as to the acceptability of such plans.[48] Each monitors compliance with

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[46] *NYSARC* v. *Carey*, *supra*, established the Willowbrook Review Panel comprised of mental retardation professionals and other concerned citizens chosen by the defendants and plaintiffs, with the authority to compile information, monitor compliance, formulate remedial plans, resolve disputes, and make recommendations to the court. *Horacek* v. *Exon*, *supra*, adopted a similar approach. *Dixon* v. *Harris*, *supra*, approved the creation of a panel but made it responsible to the plaintiffs not the court, thereby limiting its functions to fact-finding and reviewing defendants' plans for compliance.

In *Wuori* v. *Zitnay*, *supra*, an individual selected by the parties was appointed by the court with similar powers to the Willowbrook Review Panel to oversee the implementation of a consent decree concerning Pineland Center. Since the parties themselves had negotiated a detailed remedial plan, the Special Master relies on state officials to develop implementation strategies, establish timetables, and allocate specific agency responsibilities. *Accord*, *Michigan ARC* v. *Smith*, *supra*; *Brewster* v. *Dukakis*, *supra*; *MARC* v. *Dukakis*, *supra*.

Finally, a special master with broad authority to gather information, devise remedial and structural reforms, resolve outstanding disagreements between the parties, and render binding recommendations was created in *Halderman* v. *Pennhurst*, *supra*. A similar mechanism was adopted in *Gary W.* v. *State of Louisiana*, *supra*, and *Davis* v. *Watkins*, *supra*. When Alabama state officials made little effort to achieve full compliance with a 1972 court order and when less drastic monitoring devices such as human rights committees proved ineffective, the court took the more extreme step of placing the state's mental disability system in receivership, although it appointed the Governor as the receiver. *Wyatt* v. *Hardin*, C.A. No. 3195-N (M.D. Ala. Supplemental Order Jan. 15, 1980).

[47] *See, e.g.*, *NYSARC* v. *Carey*, *supra*; *Horacek* v. *Exon*, *supra*; *Wuori* v. *Zitnay*, *supra*; *Michigan ARC* v. *Smith*, *supra*; *Brewster* v. *Dukakis*, *supra*; *MARC* v. *Dukakis*, *supra*; *Gary W.* v. *State of Louisiana*, *supra*; *Wyatt* v. *Hardin*, *supra*; *Halderman* v. *Pennhurst*, *supra*. *See* Note, *Implementation Problems in Institutional Reform Litigation*, *supra*.

[48] *Id.* This is a critical function given the complexity of system-development plans, the expertise necessary to evaluate the programmatic, clinical, administrative, and fiscal details of the plan, and the judicial economies of alternative review mechanisms.

implementation plans and assists all parties in identifying and resolving obstacles.[49] Finally, some serve to resolve disputes between the parties on issues affecting individual plaintiffs or the plaintiff-class, thereby promoting a mediated compromise instead of requiring the court's adjudication of adversarial claims.[50]

Courts have traditionally exercised their equitable power to appoint persons to assist them "in the performance of specific judicial duties. . . ." *Ex parte Peterson*, 253 U.S. 300, 312 (1920). Rule 53 of the Federal Rules of Civil Procedure codifies this power. *See generally*, 5A *Moore's Federal Practice*, ¶ 53.05 (3rd ed. 1975). It has been noted that the increase in public litigation suggests the need to utilize this authority in a flexible and unconstrained, albeit judicious, manner. *See* Chayes, *The Role of Judges In Public Law Litigation*, 89 Harv. L. Rev. 1281 (1976). Thus monitors have often been appointed to carry out far-reaching decrees in school desegregation cases, *e.g.*, *Morgan* v. *Kerrigan*, 523 F.2d 917 (1st Cir. 1975), 530 F.2d 401 (1st Cir. 1976), *cert. denied*, 426 U.S. 935

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[49] *Id.* Given the numerous state and federal agencies responsible for implementing various portions of the court's order, as well as traditional bureaucratic disincentives to change, numerous obstacles to full compliance predictably arise which can best be overcome through frequent mediation and conciliation efforts by an adjunct to the court.

[50] *See Wuori* v. *Zitnay*, *supra*; *NYSARC* v. *Carey*, *supra*; *Brewster* v. *Dukakis*, *supra*; *MARC* v. *Dukakis*, *supra*. The dispute resolution function is the one most nearly approaching traditional adjudication. However, the myriad of potential controversies arising from a system in transition and the intricate relationship between particular disputes and larger implementation issues render them most appropriate for resolution by a master, with review by the court if necessary, rather than consuming scarce judicial resources in the first instance. Of course, the master's authority would only be invoked when internal and less formal settlement mechanisms proved unsucessful. *Brewster* v. *Dukakis*, *supra* (¶ 55).

Where courts have initially declined to establish an appropriately empowered mechanism to oversee implementation, they have frequently had to reconsider this issue several years later as a result of the persistent violation of their orders. *Dixon* v. *Weinberger*, 405 F. Supp. 974 (D.D.C. 1975) (Motion for the Enforcement of Decree and Appointment of a Master, July 31, 1978); *Wyatt* v. *Hardin*, *supra*, (Motion for Further Relief, Nov. 20, 1978).

(1976); reapportionment cases, *e.g.*, *Moore* v. *LeFlore County Board of Election Commissioners*, 361 F. Supp. 603 (N.D.Miss. 1972), *aff'd*, 502 F.2d 621 (5th Cir.1974); prison reform cases, *e.g.*, *Cruz* v. *Hauck*, 515 F.2d 322 (5th Cir. 1975), *cert. denied*, 424 U.S. 917 (1976); housing cases, *e.g.*, *Gautreaux* v. *Chicago Housing Authority*, *supra;* juvenile detention homes, *e.g.*, *Gary W.* v. *State of Louisiana*, *supra* (Supplemental Order, Sept. 11, 1978), *aff'd*, 601 F.2d 240 (5th Cir. 1979); and special education suits, *e.g.*, *Mills* v. *Board of Education of the District of Columbia*, *supra* (Supplemental Order, July 23, 1975). *See also cases cited in Hart* v. *Community School Board*, 383 F. Supp. 699, 765 (S.D. N.Y. 1974), *aff'd*, 512 F.2d 37 (2d Cir. 1975).

As in school desegregation cases, the federal courts have been unusually deferential in the first instance to the state agencies responsible for managing institutional facilities and establishing community care systems, leaving it to appropriate executive officials to propose remedial plans. *Bounds* v. *Smith*, 430 U.S. 817 (1977). Recognizing that these officials must ultimately bear the daily responsibility for insuring that the constitutional and statutory rights of the disabled are respected, courts have extended the defendants every opportunity to unilaterally modify and bring into compliance with existing federal and state mandates the conditions under which the government provides care to its retarded citizens.[51] When this invitation is accepted, the result is frequently a negotiated settlement or consent decree.[52] Only to the extent that state

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[51] In *Dixon* v. *Harris*, *supra*, the court patiently waited almost five years while the several federal and local defendants debated about their respective responsibilities. Even then, the court left it to the parties to prepare the plan, declining to enter any detailed directive to redress the plaintiffs' right to live in settings less restrictive than a huge federal institution. Although the court adopted a broad remedial order in *Wyatt* v. *Hardin*, *supra*, it did not move to authoritatively enforce its mandate for eight years. The Court of Appeals noted repeatedly the opportunities provided to the defendants to devise their own plan in order to avoid the necessity for any federally drafted remedy. *Halderman* v. *Pennhurst*, *supra*.

[52] In *Brewster* v. *Dukakis*, *supra*; *MARC* v. *Dukakis*, *supra*; *Wuori* v. *Zitnay*, *supra*, federal courts relied entirely on negotiations between the parties,

agencies balk at the findings and directives of the federal court are broad remedial orders required. *Halderman* v. *Pennhurst, supra.* Even then, these orders leave substantial flexibility for local governmental discretion and continue to seek the parties' cooperation in reviewing and implementing the proposed relief. *Brewster* v. *Dukakis, supra* (¶¶ 9-11, 49, 50). When persistent patterns of resistence remain, however, courts may have little choice but to order state officials to comply with detailed provisions of their order. *Hutto* v. *Finney, supra.* This is no more than what was required to translate this Court's judgment on the constitutional rights of minority children into a meaningful reality for black citizens in recalcitrant school districts. *Milliken* v. *Bradley, supra*; *Swann* v. *Charlotte-Mecklenburg Board of Education, supra.*

In virtually all suits seeking to enforce the rights of retarded citizens to live in less restrictive community programs, courts have noted that noninstitutional alternatives are professionally desirable and, in fact, clearly required under accepted state law and policy. *NYSARC* v. *Carey, supra*; *Welsch* v. *Dirkswager, supra*; *Halderman* v. *Pennhurst, supra*; *Brewster* v. *Dukakis, supra*; *MARC* v. *Dukakis, supra*; *Michigan ARC* v. *Smith, supra.* The intrusiveness of federal court intervention is thus a function of the illegality of the conditions under which retarded persons are confined and the willingness of state officials to promptly redress these violations of individual rights. *Hutto* v. *Finney, supra.* This is particularly true to the extent that a court seeks to remedy an ongoing deprivation of a constitutional or statutory guarantee as opposed to merely reviewing a previous condition. Remedial orders often do little more than incorporate federal and state governmental directives, with some further specification of compliance responsibilities, in order to increase the likelihood that traditional

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supervised by the courts, to produce a settlement and implementation plan. A similar approach succeeded in producing consent decrees in *Welsh* v. *Dirkswager,* C.A. No. 4-72 C. 451 (D. Minn. 1977); *Michigan ARC* v. *Smith, supra*; *Gary W.* v. *State of Louisiana, supra*; and *Evans* v. *Washington, supra.*

patterns of inaction will be halted. *Hutto* v. *Finney, supra.* To the extent that these orders or consent decrees propose to implement existing rights incorporated in enacted, albeit unenforced, federal and state law and policy, judicial intervention poses little threat to the independent functioning of state agencies and is entirely in conformity with traditional exercises of equitable powers.[53]

F. *States Which Have Begun to Create Community Alternatives Should Be Given the Necessary Flexibility to Design and Develop Services in Cooperation with Concerned Citizens and Responsible Professionals.*

The network of community programs which is emerging in many states throughout the country is unique to the conditions and needs of each locality. The complexity of developing comprehensive residential and nonresidential programs in geographically distinct settings and of creating an effective administrative mechanism to coordinate and monitor the delivery of appropriate services to retarded persons requires flexible and varied approaches. No single formula or design has been accepted by legislatures, state officials, or professionals. While the mandate to establish community programs as alternatives to institutions is clear, and while the guiding principles of that system are now fully accepted,[54] states must be afforded con-

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[53] That judicial monitoring is accepted by state defendants is evidenced both by negotiated settlements in most institutional litigation which include a provision for court monitors, *NYSARC* v. *Carey, supra*; *Brewster* v. *Dukakis, supra*; *MARC* v. *Dukakis, supra*, as well as by direct admission of executive officials. The Commissioner of the Maine Department of Mental Health and Corrections, testifying as a defendants' expert in *Garrity* v. *Gallen, supra*, stated that the intervention of the federal courts, together with the appointment of the Special Master to oversee the implementation of the consent decree in *Wuori* v. *Zitnay, supra*, were important factors to ensure that the defendants' obligations to create community alternatives were fully honored. (Test. of K. Concannon).

[54] Virtually all the professional literature, federal and state statutes and policies, and the negotiated settlements to pending litigation refer to the principles of normalization and less restrictive alternatives as the theoretical underpinnings of community care. *Wuori* v. *Zitnay, supra* (App. B, Sec. A);

siderable latitude in formulating the scope, content, and details of their community services.

Differences between community systems have arisen for a number of reasons. Some states have taken a comprehensive approach to replacing their institutions with less restrictive alternatives for several distinct citizen populations, including the mentally retarded, mentally ill, juveniles, and elderly, while others have focused their efforts on only one or two of these groups.[55] Some states have undertaken the development of a broad range of residential and nonresidential programs in order to provide retarded persons living in the community with effective services to prevent unnecessary reinstitutionalization rather than to simply locate alternative housing for formerly institutionalized persons.[56] Most, however, have recognized but hardly begun to implement the various legislative and executive mandates that require community services.

The uniqueness of community care systems in each state is further highlighted by the varied responses of government of-

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NYSARC v. *Carey*, *supra* (App A, Pt. A); *Brewster* v. *Dukakis*, *supra* (¶ 8(b)); *See Flynn and Nitsch*, *supra*; *See also* federal and state statutes discussed in Part II, *supra*.

[55] In addition to its commitment to disabled persons under the *MARC* and *Brewster* decrees, *supra*, Massachusetts has virtually eliminated all juvenile detention facilities and is committed to providing alternatives to nursing homes for elderly persons. Report of the Massachusetts Department of Public Health, *Alternative Care Package* (1974). Other states have similarly recognized the common element of harm attendant to all custodial institutions as well as the mounting expense associated with maintaining these facilities and providing institutional care in conformity with constitutional, statutory and regulatory requirements. *See* Calif. Welf. & Inst. Code § 5675 (West).

[56] Most negotiated settlements include a recognition that an effective and minimally adequate network of community services must include nonresidential habilitation and support programs as well as residential alternatives. *Brewster* v. *Dukakis*, *supra*, (¶ 8(a), Atts. B and C); *Wuori* v. *Zitnay*, *supra*, (App. B); *MARC* v. *Dukakis*, *supra*, (¶ 34(b)). Apart from such suits, numerous states have developed at least a limited number of housing programs for disabled persons. See *Report to the Congress* at 161-164; Heal, Sigelman, and Switzky, *Research on Community Residential Alternatives for the Mentally Retarded*, in Flynn and Nitsch, *supra*.

ficials to the almost unanimous findings of federal courts that retarded persons are being unnecessarily, inappropriately, and illegally confined in institutions due to a lack of available community programs. Although some have resisted, the majority of states have acknowledged the appropriateness of creating suitable, less restrictive alternatives and have negotiated settlements to pending litigation.[57] These consent decrees represent a consensus among all concerned parties — handicapped citizens, consumer advocacy organizations, professionals and government officers — that the mandate to develop community alternatives can no longer be delayed. Each decree incorporates the results of protracted negotiations and thus reflects a delicate balance between the particular interests of all concerned parties. Most importantly, each decree holds the promise that the historical patterns of needlessly confining retarded persons in large institutions, with the attendant deprivation of their constitutionally protected liberties, may finally be broken. Since these settlements were generally negotiated in the context of a mutually shared perception as to the constitutional and statutory responsibilities of state officials, this Court should be wary of taking any action which would disrupt the long awaited development of community alternatives or which would intrude upon the cooperative efforts of citizens and their governments in many sections of the country.

CONCLUSION.

Most public institutions which house retarded citizens in this country are a well-documented disgrace. For the retarded, the result of confinement under such intolerable conditions has been the loss of physical health, developmental potential,

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[57] *See* cases cited p. 33. Even some of those that have not entered into consent judgments have recognized the desirability of switching from institutional to community-based services and, in fact, primarily oppose the legal actions of retarded citizens because of a preoccupation with and misperception about fiscal costs. *See* Brief of Amici Curiae Illinois *et al.* 38.

and fundamental freedoms. Congress and many state legislatures have recognized this historical segregation of retarded people and mandated the creation of structured community alternatives where disabled persons can once again live normal and productive lives. That courts have had to enforce these legislative and policy directives is an unfortunate but unavoidable reality. To limit their discretion or to recall that mandate would be to consign another generation of retarded citizens to institutional stagnation.

The decision of the Court of Appeals should be affirmed.

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